| | | | State of Maryland / Department of Health and Message Amend Item 20b per fh G849 11 Certificate of Death | ental Hygie | ne 005 | 38001 |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------|----------------------------------------------|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, Last) Toney Bullock | 2. Date of Death Month | 3 2005 | 3. Time of Death 12,45A M |
| 1 | Examir | er | 4a. Facility Name (If not institution, give street and number) ROCK GIENN NUISING Rehab Baltimo | re | 4c. County of Death | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Visual Residence of Decedent | 8. Date of Birth (Month, Day, Ye | Par) & Birth Cou | place (State or Foreign ntry) And |
| | Maryland -f show | tor | 10a. State 10b. County 10c. City, Town or Location Battinore | | | 10d. Inside City Limits 1 Yes 2 No |
| | ith with the Maryla 23a or 28a-f shor ust by notified at | i Director | 10e. Street and Number 2902 Have Farel Rd. 21216 | 10g. | Citizen of What Cou | ntry? |
| 9 | within 72 hours after death with the Maryland ene. than "naturat", or Items 23a or 28a-f show he Medical Exemple mast be neithed at | Funerai | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto R | cify Yes or No- lican, etc.) | 14 Race - Ameri Black, White, | |
| 21215-0036 | "naturat", c | eted by | 15. Decedent's Education 16a. Decedent's Usual Occupation | 16b | Specify: Bla. Kind of Business/In | dustry |
| 2121 | filed within Hygiene. Ither than " | Completed | Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) College (1-4or 5+) | 9 | Domest | i'c |
| Maryland | ed la la | To Be | 17. Father's Name (First, Middle, Last) Lewis Edward Adams Marcese | ,/ | Mc/Cin | ney |
| | s 1 and 2 should if Health and Mer item 27 Is marke other traumatic | | 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Barbara Cole daughter 33 7. Bernice Are | Balto | led.21 | 229 |
| Saltimore, | Page ment o ant: If ury or | | 20a. Method of Disposition 1 © Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Carrier State Carrier State Carrier State Cem. | 19 20w - 1 | Balto. bo | own, State |
| Ball | permit. Pag Department Important: any injury o | | 21. Signature of Funeral Service Licensee Could to Could | Bald- | uf Servi | ce P.A. |
| | Physician | | 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) A C C C C R P D F F G I UT | respiratory arrest, | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | Due to (or as a consequence of): Sequentially list conditions, b. Arreno Seleratic Cardic | Vase | ular | Years |
| | be executed ician and burial-transit | Examiner | for any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | dis | ease | J |
| 8760, | the the | dical | d | | | |
| .O. Box 6 | that the death certitics ed by the attending ph detached for use as th | Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | | 23d. Date of delive Month | ery Day Year |
| rds, P | w requires that the s been signed by th should be detache | d by Pl | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacc | co use contribute to to | |
| Division of Vital Records, | The law ate has b page 2 s | 0 | 25. Was case referred to medical 26. Place of Death (| 24a. Was an autopsy performed | prior to co death? | psy findings available mpletion of cause of |
| of Vi | Phys this al dii | ToB | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28 | | 6 □Other (Specif | у) |
| vision | Attending or death. | Certification: | 1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No | | and Number or Rura | il Route Number, |
| Ō | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the fu | | 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an Check only Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred | d due to the cause | o(s) and manner as s | tated. |
| | To the H within 24 To the F complete | Medical | 29b. Signature and title of certifier 29c. License number | 29d. [| Date signed (Month, | |
| 1. | T | | American H Malen D15503 30. Name and address of person who completed cause of death (Item 23a) (Type Print) AMERICAN NAME OF DOIPHIN Street | N | ov 23 | 2005 |
| 10 | Sta | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | 18911 | עיווס | 21911 |
| Dist | Registr | ar | NOV 2 8 2005 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer DAVID BENJAMIN 22.2005 7:45A NOV. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MANOR CARE - falls road BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 6. Sex 5. Social Security Number 1 □ M 2 □ F 59 AUG. 6,1946 MARYLAND 218 42 5268 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☐ No N/A BALTIMORE MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 1526 N. BOND STREET U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: X□ Never Married 2□ Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CITYWIDE BUS CO 10TH BUS DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROBERT BENJAMIN, SR. MATTIE WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / sister l PANACEA COURT PIKESVILLE, MD. 21208 LUEASTER COPPAGE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY CEMETERY NOV. 26,2005 BALTO, MD. 4 ☐Donation 5 ☐ Other (Specify) Si nature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO, MD. 21213 Approximate Interval Between Immediate Cause (Final Lhodni disease or condition resulting in death) Due to (or as a consequence of); labele Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Human Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 □ Fetal death 4 □ Pregnant at time of death in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 41 Onknown neme 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 28 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/23/01 31464 MI) D N. Entow St Soute 308, Bultonne MI) 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Examiner

Physician/Medical

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Completed

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Certification:

Medical

Funeral

Director

it of Heelth and Mental Hygiene.
If item 27 is marked other then "naturel", or Iteme 23s or 28s-f ehow or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Pages

Depertment of Important: If eny injury or once.

Physician

/Medical

Examiner

State Registrar

31. Date filed (Month, Day, Year)
NOV 2 8 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Voar **Physician** GORDON C. CHASE 5:47AM NOV. 27, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FUTURECARE CHARLES VILLAGE BALTIMORE CITY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**XM 2□ F Director 212-36-6421 66 04/17/1939 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or iteme 23s or 28s-f show traumetic event, the Medical Examinar must be notified at 1X Yes 2 □ No HARFORD **EDGEWOOD** Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21040 CLOVERVALLEY WAY 238 1304 deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: à BLACK 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ADAMS COAL s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) DELIVERY FOR COAL CO. COMPANY 9TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CASTOR BERNICE HARRY JOHNSON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 C CLOVERVALLEY WAY, EDGEWOOD, MD 21040 DONNA COOPER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEMETERY 12/02/05 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ites
eny injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LANDSDOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fulleral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD wease, or complications that caused the de of lure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Atheroscler Physician resulting in death) /Medical Due to (or as a consequence of) Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit and Due to (or as a consequence of). attending physicien for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 10 No 1 Yes 210 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check on | one | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P after death. I Director: After 5 Pending 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aff To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 147405 30, Name and address of person who completed cause of death (ftem 23a) (Type, Print) Eutew St. Baltimore MD 2/201 MD 821-N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2005 Registrar

UNK (NJM Alli

|)5-078 sha S | | ole | | State of I | | d / Depa | | t of H | ealth a | nd Men | tal Hyg | giene eg. No: 0 | 0 5 | 38004 |
|------------------------------------------------------------------|-----------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------|-----------------------------|-----------------------------------------|-------------------------|------------------------------------------|-----------------------------|----------------------------------------|----------------------------|----------------------------------|----------------------------------------------------|
| | ysici: Medic | | | Allis | sha S. C | Colem | | | | ro/[| Month vember | | 2005 | |
| E | amin | er | 4a. Facility Name (If not institution Interstate 97 | _ | | | Fer | nda1 | | | | Anne | | del |
| | eral ctor | | 5. Social Security Number 219-04-1063 Usual Residence of Decedent | 6. Sex 7. 1 ☐ M 2 ☑ F | Age (In yrs. la 22 | st birthday) Yrs. | If Under Months | 1 Year Days | If Under 2 | | Date of Birth Month, Day Mar 11 | , Year) | 9. Birt | hplace (State or Foreign buntry) Maryland |
| death with the Marylend me 23s or 28s-f show | lied at | tor | 10a. State 10b. County Maryland | N/A | 10c. City, | , Town or Lo | ocation | В | altimore | | | | | 10d. Inside City Limits 1 X Yes 2 ☐ No |
| with the | t be not | i Direc | 10e. Street and Number 2333 West Lexingto | n Street | | | 10f. Zip | Code | 2122 | 23 | | 0g. Citizen o | of What Co | - |
| hours after death | xardinar mu | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date | ∍s? ⊑ X No | | Was Deced If Yes, spec | | ispanic Origi n, Mexican, Specify: | in? (Specify Puerto Rica | Yes or No- n, etc.) | 14. R B | lack, Whit | nican Indian, e, etc. Black |
| 10 72 thin 72 e.g. | e Medical E | Completed | (Specify only highe Elementary/Secondary (0-12) | t's Education st grade completed) College (1-4 | | 16a. Dece (Give life. | dent's Usua kind of wor DO NOT us | rk done d se retired | ation during most | of working | | 16b. Kind of Univer | | Industry |
| VIGING ZI buld be filed wi Mental Hygien arked other th | lc event, th | To Be Co | 12 17. Father's Name (First, Middle, Alexan | Last) der Coleman Jr. | | | | | | 's Name (Fil | | Maiden Sum ne Cole | | |
| Mary and 2 shou | er traumat | | 19a. Informant's Name/Relations Dollene Coleman M | | į į | i | - | | | | | r, City or Tow Maryland | | |
| permit. Pages 1 en Department of Heal | ury or oth | | 20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (S | | | ace of Disponentery, crea | osition (Name matory or of g Memo | ther plac | | Date | /30/05 | 20c, Location | | Town, State Mill, Md. |
| permit. Departr | eny Inj | | 21. Sign of Funeral Service | Licensee // // | Olar | D 2 | Es | step B | s of Facility rothers I utaw Pla | Funeral S | Service, | P. A. | | |
| Pnysi /Med | dical | | 23a. Part1. Enter the disease, or shock, or ligant failure. List Immediate Cause (Final disease or condition resulting in death) | a | sed the death. th line. | d | ter the mode | e of dyin | g, such as c | ardiac or res | spiratory ari | est, | | Approximate Interval Between Onset and Death |
| Exam | 1sit | aminer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b | аз а сспаеци | ence of). | | | | | | | | |
| 8/6U, cate be executed | e burial-transit | ũ | that initiated events resulting in death) Last | c | as a consequ | ence of): | | | | | | | | |
| . 0 | tached for use as the burial-tran | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ 1 yes 2 □ No 9 5 Unknown | | h 2∏Fetal nt at time of de | death 3 | ⊒Ectopic pro □ Other (sp | | | | | | Date of de Month | livery Day Year |
| es than | e de | Ď | Part II. Other significant conditi | ons contributing to deal | th but not resu | ilting in the u | ınderlying ca | ause giv | en in Part I. | | 23e. Did to | 1 | | o the cause of death? robably 4 Unknown |
| I Kec | irector, page 2 should b | Completed | | | | | | | | | 24a. Was a autop perior 1 Yes | sy | b. Were as prior to death? | utopsy findings available completion of cause of |
| | סי | To Be C | 25. Was case referred to medica examiner? 1X Yes 2 □ No | Hospital: 1 ☐ Ing | patient 2 2 | ER/Outpatie | nt 3 DO | Oth | ec | of Death (Ci | neck only o | | 1 | |
| 5 £ £ | 703 | 1 | 27. Manner of Death | 28a. Date of | Iniun | 28h Time o | 4 2 | Sc Inuo | | | | ow injury occ | | |

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After it completely filled in by the funera Division

1 □Natural
2 Accident
3 □ Suicide Medical Certification 5 Pending investigation 6 Could not be determined 4 - Homicide 29a. Certifier (Crisck only one)

1 ☐ Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Acknowledge: Continue Dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number **OCME**

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

November, 23, 2005

cause of death (Item 23a) (Type, Print)

111 Penn Street

State Registrar Otis Coleman 05-07694 NJM

| | | State of Maryland / De State of Maryland / De Registrar | | |
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| Physici | an | 1. Decedent's Name (First, Middle, Last) | COIE MAN November | Day Yeer |
| /Medic Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
| Funeral | 35 | Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda | Baltimore Baltimore Baltimore Bit Under 1 Year If Under 24 Hrs. 8. Date of Birt | h 9. Birthplace (State or Foreig |
| Funeral Director | | 216 685756 17 M 2□F 49 Yrs. Usual Residence of Decedent | Months Days Hours Min (Month Da | 1-1956 Country S C |
| within 72 hours after death with the Maryland ene. than "natural", or Itame 23e or 28e-f ehow ha Madeal Examinar must be notified at | tor | 10a. State 10b. County MA 10c. City, Town or RAIT | LIMORE | 10d. Inside City Limit |
| s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itame 23e or 28e-f ehov other traumatic event, the Medical Examinar must be notified at | Funeral Director | 10e. Street and Number 16 24 m 1 + An QUE | | 10g. Citizen of What Country? |
| ter death Itame 23 | unera | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No | Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Bfack, White, etc. |
| ural, or | þ | 3 Widowed 4 Divorced ff Yes, Give Year or Dates: | 1 ☐ Yes 2 No Specify: | Specify: BIAC T |
| 2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural; 'aumatic event, tha Medical Exo | Completed | (Specify only highest grade completed) (Gillementary/Secondary (0-12) College (1-4or 5+) | cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired) | 16b. Kind of Business/Industry |
| filed w Hygier other ti | Be Col | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, | FOOD SERVICE Maiden Surmame) |
| hould be d Menta marked matic ev | ToB | | DAN . JR DORALY ailing Address (Street and Number or Rural Route Number | BUCHANAN |
| ss 1 and 2 so Health an item 27 is cother traus | | Dorothy Coleman 16. | 34 Miton AVE BA | |
| Pages 1 ent of He nt: If iter ry or oth | | 20a, Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | sposition (Name of remaiory or other place) RMEI CEM Date 1/19/2065 | 20c. Location - City or Town, State BAI+& MB |
| permit. Pages Depertment of Importent: If I any Injury or one | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility BAI | to MB 21213 |
| (= | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. | Ph:11 -P A.WEA THER FOR O enter the mode of dying, such as cardiac or respiratory ar | |
| /Medical Examiner bhysicien and sthe burial-transit | icai Examiner | disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | |
| that the death certifica ed by the attending ph detached for use es th | Completed by Physician/Medical | | 3 Ectopic pregnancy 5 Other (specify) | 23d. Date of delivery Month Day Year |
| tth. | d by P | Part II. Other significant conditions contributing to death but not resulting in the | | bacco use contribute to the cause of death? (es 2 □ No 3 □ Probably 4 ☑Unknow |
| juires that the n signed by the ild be detach | | | | |
| in: The law requires that the ificate has been signed by th or, page 2 should be detach | | 25. Was case referred to medical | | sy prior to completion of cause of death? 2 □ No 1 □ Yes 2 □ No |
| ysicien: The law requires that the is certificate has been signed by the director, page 2 should be detach | 9 | 25. Was case referred to medical examiner? 1 [XYes 2 □ No Hospital: 1 □ Inpatient 2X ER/Outpat | autop perfor 1 Yes 26. Place of Death (Check only or | sy prior to completion of cause of death? 2 □ No 1 □ Yes 2 □ No 7e) |
| nding Physician: The law requires that the thir. Ith: After this certificate has been signed by the funeral director, page 2 should be detach. | To Be | examiner? 1 XYes 2 No Hospital: 1 Inpatient 2X ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time | 26. Place of Death (Check only or | sy prior to completion of cause of death? 2 No 1 Yes 2 No |
| ng Physician: The law requires Iter this certificate has been sign neral director, page 2 should be | To Be | examiner? 1 XYes 2 No Hospital: 1 Inpatient 2X ER/Outpat 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Hospital: 1 Inpatient 2X ER/Outpat 28a. Date of Injury 28b. Time Injury 1 Could not be determined 28b. Place of Injury - At home, farm, building, etc. (Specify) | autop perfor 26. Place of Death (Check only or tient 3 DOA) Other: 4 Nursing Home 5 Resid a of 28c. Injury at Work? 1 Yes No 28d. Describe h | sy prior to completion of cause of deeth? 2 No 1 Yes 2 No ne) lence 6 Other (Specify) ow injury occurred unk itreet and Number or Rural Route Number, m, State) 1634 N. Milton |
| Hospitel or Attending Physician: The law requires that the 24 hours after death. Funerel Director: After this certificate has been signed by the teneral director, page 2 should be detachletely filled in by the funeral director, page 2 should be detach. | Certification; To Be | examiner? 1 XYes 2 No Hospital: 1 Inpatient 2X ER/Outpat 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury F. (Month, Day Year) FOR outdoor to be a control of the | 26. Place of Death (Check only or performance) 28. Injury at Work? 1 | prior to completion of cause of deeth? 2 □ No 1 □ Yes 2 □ No ne) ence 6 □ Other (Specify) ow infury occurred unk irreet and Number or Rural Royte Number, m, State) 1634 N. Milton re, MD |
| To the Hospitel or Attending Physicien: The law requires that the within 24 hours after death. To the Funerel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detacht. | To Be | examiner? XYes 2 No | autop performed to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place, and due to the course at the time, date and place at the time. | prior to completion of cause of deeth? 2 □ No 1 □ Yes 2 □ No ne) ence 6 □ Other (Specify) ow infury occurred unk irreet and Number or Rural Royte Number, m, State) 1634 N. Milton re, MD |
| To the Hospitel or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. | Certification; To Be | examiner? 1 XYes 2 No Hospital: 1 Inpatient 2X ER/Outpat 2 Accident 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Acciding Injury - At home, farm, building, etc. (Specify) Found in resident 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, default and manner stated. | autop performing the street, factory, office 26. Place of Death (Check only or Yes) 26. Place of Death (Check only or Yes) 28d. Describe have a continuous at Work? 1 Yes | prior to completion of cause of deeth? 2 □ No The proof to completion of cause of deeth? 1 □ Yes 2 □ No The proof to completion of cause of deeth? The proof to completion of cause o |

| | | 4 | For State Registrar | te of Maryland / Dep <i>Ce</i> | artment of Healt <i>rtificate of Dea</i> | | ntal Hygie | 2005 | 38006 |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle, Last) | | | 2 | . Date of Death | | 3. Time of Death |
| | /Media | | | lligan | · · · · · · · · · · · · · · · · · · · | | ovember 22 | | 9:31 a. M |
| | Examir | | 4a. Facility Name (If not institution, give street a Johns Hopkins Hospital | | 4b. City, Town, or Locat Baltimore | | | 4c. County of Death | |
| | Funeral Director | | 5. Social Security Number 102-32-0580 1 M 2 Usual Residence of Decedent | 7. Age (In yrs. last birthday) 63 Yrs. | If Under 1 Year If Ur Months Days Hou | urs Min. | Date of Birth (Month, Day, Ye une 6, 1 | 9. Birth <i>Cou</i> | place (State or Foreign intry) EW York |
| | /land | | 10a. State 10b. County | 10c. City, Town or L | ocation | | <u> </u> | | 10d. Inside City Limits |
| | Man e-fsh | ctor | Maryland N/A | Baltir | nore | | | | 1X Yes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | 10f. Zip Code | | 10g. | Citizen of What Cou | intry? |
| | eth w | ral | 900 South Baylis S | | | 1224 | | United S | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28e-f show apprintly or other traumatic event, the Mudical Examiner must be notified at anone. | by Funeral | 1 Never Married 2 Married 1 If Y | s Decedent Ever in U.S. ned Forces? JYes 2 XI No es, Give X ar or Dates: | Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 No Spe | | fy Yes or No- can, etc.) | 14. Race - Ameri Black, White Specify: | |
| ŏ | 2 hou | ted | 15. Decedent's Education | | dent's Usual Occupation | | 166 | o. Kind of Business/Ir | |
| 21215-0036 | ed within 7 giene. er than "n | Completed | 10 | | kind of work done during of DO NOT use retired) Writer | most of working | | Publishi | ng |
| Maryland | ould be file Mental Hy arked oth | To Be | 17. Father's Name (First, Middle, Last) George H. Colligan | | 18. M | Mother's Name (I | First, Middle, Maid el Kiel | den Sumame) rnan | |
| Mar | nd 2 sho sith and 27 is mu r trauma | | 19a. Informant's Name/Relationship (Type, Pri. Mrs. Susan A. Colliga | | ng Address (Street and Nu South Baylis | | | ity or Town, State, Zi imore. MD | |
| Baltimore, | ages 1 al nt of Hee t: If item / or othe | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova | 20b. Place of Disposementery, cre | osition (Name of matory or other place) | Dat | e 20c | Location - City or T | own, State |
| Baltir | permit. P Departme Importan any injuri | | . 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licensee | chael F Canapp 2 | Service Corp 2. Name and Address of Fa Leonard J. Ruck | | | lowson, dRoad aryland 212 | Maryland 214 |
| | | | 23a. Part1. Enter the disease, or complications | that caused the death. Do not en | | | | | Approximate |
| | Physician | | shock, or heart failure. List only one caus Immediate Cause (Final disease or condition | | athrosel | Isvotic | Hardi | 100 SC . 1 | Interval Between Onset and Death |
| | /Medical | | resulting in death) a. — | ou to (or as a consequence of): | 7,7070.01 | , , . | | 18858 | |
| | Examiner | L | Sequentially list conditions, if any, leading to immediate | | | | 4 | 10179 | |
| | ted sit | Examiner | cause. Enter Underlying Cause (Disease or injury | lue to (or as a consequence of): | | | | | |
| | execu n and al-trai | Exan | that initiated events c. | ue to (or as a consequence of): | | | | | |
| 58760, | icate be executed physician and s the burial-transit | dical | d | | | | | | |
| | | Medi | IS SCHALE | | | | | | |
| O. Box | requires that the death certifi een signed by the attending I hould be detached for use as | Physician/Me | in the past 12 months? | | Ectopic pregnancy Other (specify) | | | 23d. Date of deliv Month | ery Day Year |
| , P.O | that the | | Part II. Other significant conditions contributing | g to death but not resulting in the u | nderlying cause given in Pa | art I. | 23e. Did tobacc | co use contribute to t | he cause of death? |
| rds | v requires been sign should be | ed by | | | | | 1 ☐ Yes | 2 □ No 3 □ Prot | pably 4 Unknown |
| Records, | aw is b | Completed | | | | | 24a. Was an autopsy | 24b. Were auto | psy findings available mpletion of cause of |
| - | icien: The l certificate ha rector, page | | | | | | performed 1 ☐ Yes 2 | ? death? | |
| Vital | | Be c | 25. Was case referred to medical examiner? Hospital | | Other | Place of Death (| | | |
| of | | n: To | A192 5 140 | Date of Injury 28b. Time of | f 28c. Injury at | | Residence Describe how in | 6 ☐Other (Specification) | (y) |
| ion | Attending or death. ector: After by the fune | atlo | 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) Injury | Work? M 1 ☐ Yes 2 | | | ,., | |
| Division | el or Attencs after death | Certification; | 3 Suicide 6 Could not be determined 28e. | Place of Injury - At home, farm, stibuilding, etc. (Specify) | reet, factory, office | 28f | Location (Street City or Town, St | and Number or Rura ate) | ul Route Number, |
| | To the Hospitel or Attend within 24 hours after deatt To the Funeral Director: completely filled in by the | Medical (| (Check only 2 Medical Examiner: Or | To the best of my knowledge, deat the basis of examination and/or in dimanner stated. | h occurred at the time, date vestigation, in my opinion, | e and place, and death occurred | I due to the cause at the time, date a | e(s) and manner as s and place, and due to | tated. o the cause(s) |
| | To t withi To tl | Σ | 29b. Signature and title of certifier | 10- | 29c. License numb | | 29d. | Date signed (Month, | Day, Year) |
| | 4 | | Calrier 77 | 45 | UCM | 1E | 1 | 1/23/20 | vos |
| (| l | | 30. Name and address of person who complete | cause of death (Item 23a) (Type, | Print) /// Pfus | stroo | + Ra | Himove. | MD 21201 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2. 8 2005 | 32. Rogistrar's Signature | berte | , -//+ | 1 12-1 | -,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 1 2/20/ |

| | | | For State Registrar | State | of Marylan | • | rtment o | | | lental Hygi | ene g. No. |)5 | 380 | 07 |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------|---------------------------------------------|--------------------------|-----------------------|----------------------------------------|----------------------|
| | Physicia | | Decedent's Name (First, Middle | | | | | | | 2. Date of Death Month NOV. 11 | , Day 2005 | Year | 3. Time of 1:45 | Death Am |
| | /Medic | al | Rose Marie Ca | | ım ber) | | 4b. City, Tow | n, or Location | of Death | 1100. 11 | 4c. County | of Death | 1.43 | |
| | Examin | ier | Suburban Hosp | - | | | Bethe | | | | | gomei | -Y | |
| | Funeral Director | | 5. Social Security Number 352-07-5600 | 6. Sex 1 □ M 2 X F | 7. Age (In yrs. 9 | | If Under 1 You Months Da | | 24 Hrs. Min. | 8. Date of Birth (Month, Day, OCt. 1, | 1910 | 9. Birthp | lace (State o try) LNOIS | r Foreign |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | , | 10c. Cit | ly, Town or Lo | cation | | | | | 1 | 0d. Inside Ci | ty Limits |
| | Maryl | 호 | VA Fairf | ax | Sp | ringfi | eld | | | | | | 1 ☐ Yes | 2 ₹No |
| | a with the | Funeral Director | 10e. Street and Number 7775 Tangier I | Or. | | | 10f. Zip Coo 2215 | | | 10 | og. Citizen of V USA | Vhat Cour | ntry? | |
| 30 | be filed within 72 hours after death with the Maryland ital Hygiana. ed other then "natural", or Iteme 23a or 28a-f ehow event, the Madical Examinat must be nutified at | by Funer | 11. Marital Status 1 □ Never Married 2 □ Mai 3XXV/Vidowed 4 □ Divorced | ned 1 ☐ Yes If Yes, G | 2 X2N o ive | | Was Decedent f Yes, specify (1 ☐ Yes 2☐ | | | ecify Yes or No- Rican, etc.) | | k, White, | | |
| 2-003e | Phour | | 15. Deceder | nt's Education | | 16a. Dece | dent's Usual O | ccupation | | | 16b. Kind of Bu | | | |
| 213 | ithin 72 na. hen "na | Completed | (Specify only higher Elementary/Secondary (0-12) | est grade completed | (1-4or 5+) | (Give | kind of work de DO NOT use re ymaker | one during mos stired) | st of worki | ing | Chocol | | | |
| V | Hygi Hygi H, | Col | 12 17. Father's Name (First, Middle, | Last) | | Cario | ymaker | nal8 Moth | er's Name | o (First, Middle, A | | | | |
| yland | 2 should be and Mental le marked o | To Be | 17 Father's Name (First, Middle, Andolfo Mazzar | ese | | | | | | | | | | |
| Mar | s 1 and 2 should if Heelth and Men Item 27 le marke other traumatic | | 19a. Informant's Name/Relation Carol Belkin/ | | | | | | | al Route Number, ngfield, | | | Code) | |
| aitimore, | Pages 1 a ent of He nt: If Item ry or other | | 20a. Method of Disposition 1 ☐ Burial 2XXCremation 4 ☐ Donation 5 ☐ Other (3) | | State (| cemetery, crei | sition (Name of matory or other Cremato | place) | | Date 13, 2005 | 20c. Location - Falls | • | | Α |
| Balti | permit. Pages 1 Depertment of H Important: If Ite any Injury or ot once. | | 21. Signature of Funeral Service | Licensee | Tess | 22 | | | | maine Fu Rd. Spri | | | | |
| | | | 23a. Part1. Enter the disease, of shock, or heart failure. Lis | or complications that t only one cause on | caused the deal | th. Do not ent | er the mode of | dying, such as | s cardiac o | or respiratory arre | est, | | Approximat Interval Bet | ween |
| } | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a | F | | 400 | NIA | | | | - 7 | Onset and I | Death |
| | Examiner | | | | o (or as a consec | quence of): | | | | | | | | |
| H | p is | Iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Cuato | (or as a consec | prience of): | | | | | | 1 | | |
| | certificate be executed ding physicien and use as the burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to | o (or as a consec | quence of): | | | | | | - | | |
| 9/8 | ate be hysicie the bur | dical | | d | | | | | | | | | | |
| Box 6 | death certific e attending p id for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 1□Live 4□Preç | utcome of pregn birth 2 ☐ Feta gnant at time of c | al death 3 | ∃Ectopic pregn ∃ Other (specif | | | · · · · · · · · · · · · · · · · · · · | | te ol delive onth | * | Year . |
| J. | ires that the de signed by the a I be detached t | Phys | 9 Unknown | 9□ Unk | | aultina in the . | adashiaa aasa | e swon in Dest | 1 | 220 Dirt to | pacco use cont | ributo to t | ha agusa of s | loath? |
| ords, | w requires the been signed should be d | ted by | Part II. Other significant condit | ions contributing to | | salang in the t | | e given in Fan | | 1 🗆 Ye | \sim | | ably 4 🔠 | |
| Vital Records, | ES CA | Completed | | | | | | | | 24a. Was a autops perfor | y ngd? | prior to co death? | opsy findings mpletion of c 2□No | available ause ol |
| Ita | | Be C | 25. Was case referred to medic examiner? | | | | | 1/ | e of Deat | h Check only on | 4 | | | |
| | Physic this co | 유 | 1 ☐ Yes 2 No 27. Manper of Death | | | ER/Outpatie | | The second second | - | ome 5 Reside | | | 'y) | |
| ono | Attending Physician: It death. ector: After this certification is the funeral director. | atlon | 1 Naturai 5 ☐ Pend | | e of Injury onth, Day Year) | Injury | M 280. | Injury at Work? 1 ☐ Yes 2 ☐ | | 28d. Describe ho | ow injury occur | 190 | | |
| Division of | of or Attendiates after death. I Director: A in by the fu | Certification: | 3 ☐ Suicide 6 ☐ Could | mined 286. Plat | ce of Injury - At h ding, etc. (Speci | | reet, factory, of | fice | | 28I. Location (St City or Town | | per or Rura | al Route Num | ber, |
| | To the Hospitel or Attending Ph within 24 hours aftar death. To the Funeral Director: After th Somplately filled in by the funeral | Medical C | | ing Physicien: To the and ma | | | | | | | | | | 3) |
| | To the within To the compli | Me | 29b. Signature and title of certifi | ier | A / | | 29c. L | cense number | | | 9d. Date signe | | | |
|) | 2 | | > Will | - HOVV | Vuly) | | D | 1808 | 4 | 11 | bugu | BER | 11,20 | 005 |
| | 0 | | 30, Name and address of perso | ATEL, | use of death (Ne | | | 058 R | 0, K | OCKUL | LIEM | 02 | 085 | 2_ |
| | St Regist | ate trar | 31. Date filed (Month, Day, Yea | n) 32. | Registrar's Sign | ature | est y | | / | | , | | | |
| | | | L NIIV & i | LUUJ JEE | ASSOLA A | 1 100 | The state of the s | | | | | | | |

CASA RETO

| 37710 | | 1 - For State Registrar | State of Ma | | partment of Hea | | | ene () (|) 5 | 380 | 800 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------|-------------------------------------------------------------------------|-------------------------------------|----------------------------------|-------------------|-------------------------|---------------------------|------------|
| | | Decedent's Name (First, Middle, La | st) | | | | 2. Date of Death Month | 1 | Vasa | 3. Time o | f Death |
| Physic /Medi | | | Tony D | ale Cam | pbell | | Novembe | $r^{Day}23$ | 2005 | 8:32 | Р м_ |
| Examir | | 4a. Facility Name (If not institution, giv | e street and number) | | 4b. City, Town, or Loc | ation of Death | | 4c. County | | | |
| | | Bon Secours Hosp | | | Baltimore | | | | | /A | |
| Funeral | | 5. Social Security Number 6. S 214-64-0945 | ex 7.Age □X/ 2□F | (In yrs. last birthda 51 Yrs. | | Under 24 Hrs. ours Min. | 8. Date of Birth (Month, Day, | Year) | 9. Birthp | lece (State of | or Foreign |
| Director | | Usuel Residence of Decedent | | 51 Yrs. | | | Sep 18 | , 1954 | Ţ | Maryland | 1 |
| /land | | 10a. State 10b. County | | 10c. City, Town or | Location | | | | 1 | 0d. Inside C | ity Limits |
| Mar | ip | Maryland | N/A | | Balti | more | | | | 1 ☐Yes | 2 □ No |
| or 28 | ire | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of V | | - | |
| 23a unit b | Funeral Director | 213 Furrow Street | | | | 21213 | | | U.S. | A. | |
| tems | nue | 11. Marital Status | 12. Was Decedent Ev Armed Forces? | ver in U.S. | Was Decedent of Hispar If Yes, specify Cuban, M | nic Origin? (Spe lexican, Puerto | acify Yes or No- Rican, etc.) | | e - Americ k, White, | | |
| s afte | by F | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: |) | 1 ☐ Yes 2 ☐ Xio Sp | pecify: | | Specify | <i>r:</i> | Black | |
| hour | edt | 15. Decedent's E | 1 | 16a. Dec | cedent's Usual Occupation | | | 6b. Kind of B | ısinass/Inc | fustry | |
| n nertic | plet | (Specify only highest gra Elementary/Secondary (0-12) | | (Gi | ve kind of work done durin . DO NOT use retired) | | ing | | | - | n/ |
| d with displaying the street of the street o | Completed | 12 | College (1-401 5+ | , | Laundi | ryman | | Op- | 10-Dau | e Laundi | У |
| be filed within 72 hours after death with the Maryland that Hygiene. Id other then "netural", or items 23a or 28s-f ehow event, the Medical Eracifier must be redified at | Bec | 17. Father's Name (First, Middle, Last, | | | 18. | Mother's Name | (First, Middle, M | | | | |
| al yialic should be f and Mental b marked ol omatic eve | 2 | Lloyd | Howard | | | | Jear | Campb | ell | | |
| (4 | | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Ma | illing Address (Street and I | | | | | Code) | |
| tand tand Health em 27 ther tr | | Esther Pope | | 20h Blace of Die | 2308 West Lexing | | - | | | | |
| Pages 1 nent of h int: if its | | 20a. Method of Disposition 1 □ 1/9 urial 2 □ Cremation 3 □ | | cemetery, c | position (Name of rematory or other place) | 1 | 11/29/05 | Oc. Location - | - | wn, State Marylar | , d |
| Definition Pages Sermit. Pages Sepertment of mportant: If in any injury or once. | | 4 ☐ Donation 5 ☐ Other (Specifical Signature) Funeral Service Licer | | | VIt. Zion Cemetery 22. Name and Address of | | 11/28/05 | Latio | downe, | iviai yiai | iu |
| permit. Deperting imports ony inj | | | 5/8 | 7) | | | ral Service, I altimore, Md | P. A. | | | |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused t | e death. Do not e | enter the mode of dying, su | ich as cardiac o | or respiratory arre | 21217 st, | | Approximat | te |
| Physician | | Immediate Cause (Final | Gunshit | | 1 | 4 | | | | Interval Bet Onset and | |
| /Medical | | disease or condition resulting in death) | a | consequence of): | 1 M CHE. | ' \ | | | | | |
| Examiner | | Sequentiathy list conditions | h | | | | | | | | |
| P # | Iner | Sequentially list conditions, it any, leading to annustrate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a | consequence of): | | | | | | | |
| and I-trans | Examin | that initiated events resulting in death) Last | C | consequence of): | | | | | - | | - |
| BUX 00100, eath certificate be executed attending physician and for use as the burial-transit | cai E | | Due 10 (01 a3 a | consequence or). | | | | | | | |
| phys s the | | | d | | | | | | | | |
| certii nding use a | N/W | fF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of | | | | | 23d. Dat | e of delive | rv | |
| death atter | clar | in the past 12 months? | 1 ☐ Live birth 2 4 ☐ Pregnant at ti | - | B □Ectopic pregnancy 5 □ Other (specify) | | | Mo | | • | Year |
| by the | Physician/Med | 9 Unknown | 9□ Unknown | | | | | | | | |
| e law requires thet the de has been signed by the ige 2 should be detached | by P | Part If. Other significant conditions of | ontnbuting to death but | not resulting in the | underlying cause given in | Part I. | 23e. Did tob | acco use cont | ribute to th | e cause of o | death? |
| equir sen si ould i | | | | | | | 1 🗆 Ye | s 200 No | 3 Prob | ably 4 □l | Jnknown |
| law r las be s 2 sh | Completed | | | | | | 24a. Was an | | | osy findings | |
| The The Sete h | Con | | | | | | / perform | ed? | leath? X Yes | | |
| cien: sertific ector. | Be | 25. Was case referred to medical examiner? | Manadal | | | Place of Death | (Check only one |) | | | |
| Physi this o | ၉ | 1 XXes 2 No 27. Manner of Death | Hospital: | | | | me 5 ☐ Resider | | | ') | |
| or Attending Physicien: The later death. Director: After this certificate ha in by the funeral director, page | Pol | 1 ☐ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day | _ | Work? | 2 NO | 28d. Describe how | | ed Cl. at | _ | |
| ttend death ctor: / the | Ical | 2 Accident investigatio 3 Suicide 6 Could not b | 9 29a Place of Injus | | street, factory, office | | 28f. Location (Str. | Outus and Numb | D WO I | Route Num | 1bor |
| after Dire | Certification: | 4 Homicide determined | building, etc. | (Specify) | home | | City or Town, | State) 212 | Fur | on st | eet |
| To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | | 29a. Certifier 1 Certifying Ph | ysician: To the best of | my knowledge, de | ath occurred at the time, d | ate and place, a | Sculting and due to the ca | use(s) and ma | nner as st | ated. | |
| he Hc in 24 i he Fu pletek | edical | (Check only 2 Medical Examone) | niner: On the basis of e and manner state | xamination and/or | investigation, in my opinion | n, death occurre | ed at the time, da | te and place, | and due to | the cause(s | ;) |
| To t To tl | × | 29b. Signature and title of certifier | | | 29c. License nur | mber | 29 | d. Date signed | (Month, I | Day, Year) | |
| . / | 1 | I highw, | mid | | 00 | CME | No | ovember | 24, | 2005 | |
| 6 | | 30. Name and address of person who | - | ath (Item 23a) (Typ | | Itmost | Dol+ima- | co Mor | nz1 ax | 1 2120 |)7 |
| | | 31. Date filed (MorMn) Day, Year). | M H 32. Registrar | 'e Cianatura | 111 Penn S | rreer | рат (ШЮ) | le, Mar | утап(| | 11. |
| Sta Regist | | The same more program, way, really | Sz. Registrar | o orginature | 0 | | | | | | |

DHMH 17 Rev 1/2001

Registrar

ELCANOL

ORIGINAL

CPM 05-07914 Joseph Cobb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 - For State Registrar | | aryland / Dep <i>Ce</i> | artment of H | | | iene 2005 | 38010 |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------|----------------------------------|---------------------------------------------|---------------------------------------------------------|----------------------------------------------------------|
| I | Physici /Medic | | Decedent's Name (First, Middle, Last Joseph Allen Cobb | | | | | 2. Date of Death Month Novembe | Day Year | 3. Time of Death 16:58 M |
| - | Examir | | 4a. Facility Name (If not institution, give University Hospit | al-Shock : | | 4b. City, Town, or Baltin | ore | | 4c. County of Death | |
| | Funeral Director | | 5. Social Security Number 6. S 214-50-5047 Usual Residence of Decedent | ox □M 2□F | e (In yrs. last birthday, 55 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 11/29/1 | Year) 9. Binth 949 Mary | nplace (State or Foreign untry) yland |
| | e Maryland | ctor | 10a. State 10b. County Maryland n/a | | 10c. City, Town or Lo Baltimore | | | | | 10d. Inside City Limits Y☐ Yes 2 ☐ No |
| | sath with thes 23a or 26 | eral Director | 10e. Street and Number 2317 James Street | 12. Was Decedent | Surviva II C | | 230 | | Og. Citizen of What Cou | |
| 920 | ours after d ral', or Item Examinar | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates: | No | Was Decedent of His If Yes, specify Cubar | Specify: | Rican, etc.) | 14. Race - Amer Black, White Specify: V | |
| 21215-0036 | be filed within 72 hours after death with the Maryland tal Hyglene dother then "natural", or items 23a or 28a-f ehow event, tra Medical Examinat must be notified at | Completed | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) | | (Give life. | dent's Usual Occupa kind of work done d DO NOT use retired, | urina most of work | ing | 16b. Kind of Business/li | , |
| Ē | 0 7 5 | To Be Co | 12. 17. Father's Name (First, Middle, Last) Eugene C. Cobb | | Iruc | ck Driver | | e (First, Middle, M • Houliha | | n |
| e, Mary | l and 2 sho lealth and h m 27 le ma her trauma | | 19a. Informant's Name/Relationship (7) Brenda L. Cobb ? | • | 2317 | James Str | eet, Bal | timore, 1 | City or Town, State, Zi Maryland 21 | 1230 |
| Baltimore, | permit. Pages 1 and 2 should b Department of Health and Menti Important: If Item 27 Is marked any Injury or other traumatic s ance. | | 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen |) | Glen Hav | osition (Name of matory or other place en Mem. P) 2. Name and Addres | c. 11/29 | 9/05 G | 20c. Location - City or T Elen Burnie Ineral Home | , Md. |
| | | | 23a. Part1. Efter the disease, or compshock, or heart failure. List only | one cause on each in | the death. Do not en | ter the mode of dying | IS AVEITUE I, such as cardiac | , Baltim | ore, Maryl | |
| | Physician /Medical Examiner | | disease or condition resulting in death) | Due to (or as | a consequence of): | ot wound | of h | ead | | |
| 8760, | ate be executed thysician and the burial-transit | Ilcai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequence of): a consequence of): | | | | | |
| P.O. Box 6 | The law requires that the death certificate be executed the has been signed by the ettending physician and oage 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of delive Month | very Day Year |
| ords, F | w requires that been signed I should be det | <u>ک</u> | Part II. Other significant conditions of | ontributing to death be | ut not resulting in the u | nderlying cause give | n in Part I. | 23e. Did toba | acco use contribute to s | the cause of death? |
| | | Completed | OF Was and referred to resting | | | | | | prior to co death? No 1 Yes | opsy findings available ompletion of cause of 2 No |
| = | ysicia is certi directo | To Be | 25. Was case referred to medical examiner? 1 Yes 2 □ No | Hospital: 1 Inpatie | nt 2 ER/Outpatie | Otho | _ | h <i>Check</i> only one | nce 6 Other (Speci | 4.1 |
| Division of | ding Ph h. After th funeral | Certification: 7 | 27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation 3 Sucide 6 Could not be | 28a. Date of Injui (Month, Day 11-23-05 | y Year) 28b. Time o Injury 14-24 | f 28c. Injury Work 1 U | at ? es 2 No | subject | winjury occurred Shot hims | elf |
| Z Z | To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the | | 4 Homicide determined 29a. Certifier 1 Certifying Ph | building, etc. | of a bus | iness stor | Q date and place | Glen Bur | nie mD | y wagher Lane |
| | the Ho lin 24 I the Fu | Medicai | (Check only 2X Medical Exam | iner: On the basis of and manner sta | examination and/or in | vestigation, in my op | inion, death occurr | red at the time, dat | te and place, and due t | o the cause(s) |
| ١. | S til C O | 2 | 29b. Signature and title of certifier | mid | | | .C.M.E. | | ovember 24, | |
| $h_{i_{j_{1}}}$ | Sta | ate. | 30. Name and address of person who defined Ling Ling 131. Date filed (Month, Day, Year) | miD | | | et, Balt | imore, Ma | aryland 212 | .01 |
| DHM | Registi | ar | NOV 2 8 | 2005 | w. H | Jorde | | | | |
| | | | | | ORIGI | NAL | | | | |

| D | | | 1 - For Unpend Item | State of Mar 23a,27,28a- | yland/Dep f per me | artme | ent of Health 0,1272,05 | n and N | lental Hy | gien | e _ | 20011 |
|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------|-------------------------------------------------------|------------------------------|---------------------------------|------------------|-------------------------------------|-----------------------------------------------|
| | | | Decedent's Name (First, Middle, L.) | | | Tunce | ale of Deal | | 2. Date of De | nay. N | 2005 | 380 |
| | Physic /Medi | | George Ed | ward Davis | ı. Jr | | | | NOVEMBE | Da | 2 2005 | 2:20A. M |
| | Exami | | 4a. Facility Name (If not institution, g | ve street and number) | ,, | 4b. C | ity, Town, or Location | on of Death | I TO VILLIDI | | c. County of Dea | |
| 0 | | | JOHNS HOPKINS BAY | VIEW CARE CH | ENTER | BA | LTIMORE | | | | N/A | |
|) [| Funeral | | | | n yrs. last birthday) 8 Yrs. | If Un Month | | der 24 Hrs. | 8. Date of Birt | th V. Year | Q Di | thplace (State or Foreign ountry) |
| 3 | Director | | 213-90-5181 Usual Residence of Decedent | | 8 Yrs. | <u> </u> | | | June Da | 9 | 1977 й | aryland |
| | yland | | 10a. State 10b. County | 10 | Oc. City, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| | e Ma | ctor | Maryland N/ | A | | Bal | timore | | | | | 1√2Yes 2 No |
| | with th | Dire | 10e. Street and Number 3411 W. Fores | - D - 1 - 2 | | 10f. | Zip Code | | | 10g. Ci | itizen of What C | ountry? |
| | s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heeth and Mental Hygiene. If Heeth 27 is marked other than "neturel", or iteme 23e or 28e-f show other treumatic event, tre Madical Examinating an additional. | Funeral Director | | | | | 21216 | | | | USA | |
| 40 | fter d | P. | 11. Marital Status 1 ☐ Never Married 2 ☑ Married | 12. Was Decedent Eve Armed Forces? | or in U.S. 13. | Was De If Yes, s | cedent of Hispanic (pecify Cuban, Mexic | Origin? (Specan, Puerto | ecfy Yes or No- Rican, etc.) | | 14. Race - Ame Black, Whi | |
| 99 | urs ai | þ | 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | | 1 🗆 Yes | X□ No Specif | ity: | | | Special lac | |
| 5-0 | 72 ho | Completed | 15. Decedent's I | ducation | 16a. Dece | dent's U | sual Occupation | | | 16b K | (ind of Business | |
| 21 | nen | nple. | Elementary/Secondary (0-12) | College (1-4or 5+) | (Give | Rind of DO NOT | sual Occupation work done during m use retired) | ost of worki | ng | | | ,oustry |
| 2 | lied w tygien her ti | Ö | 10th grade | | Curio | ous | George | | | | Lf-Emp | Loyed |
| anc | ntal Hed of | Be | 17. Father's Name (First, Middle, Las George E. Dav | is | | | | | (First, Middle, | | | |
| Ž | should Ind Men | 5 | 19a. Informant's Name/Relationship | | | | | | Valen | | | |
| S | od 2 s lift an 27 ts | | Qiona Davis/W | | 19b. Mailir | ng Addre | Street and Num | Do l- | Route Numbe | r, City | or Town, State, 2 | Zip Code) |
| <u>9</u> | f Hee f Hee othe | | 20a. Method of Disposition | | | | | Park | AVE B | alt | ocation - City or | Md 21216 |
| Baltimore, Maryland 21215-0036 | permit. Peges Depertment of Importent: If II eny Injury or o | | ★★Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Spec. | Removal from State | cemetery, cren | n <i>atory</i> o | r other place) | | | | | , Maryland |
| alti | permit. Depertir Importe eny inju | | 21. Signature of Funeral Service Lice | - | 22 | . Name | and Address of Fac | :iiivCha | tman-H | Ld! | isdowne | e,Maryland eral Home |
| 8 | 89 5 8 | | Jerry / | arvois | 52 | 240 | Reister | stow | n Rd B | alt | imore. | Md 21215 |
| | | | 23a. Part 1 Enter the disease, or consheck, or heart failure. List only | plications that caused the | death. Do not ent | er the mo | ode of dying, such a | as cardiac o | r respiratory arr | est, | | Approximate |
| 9 | Pnysician | | Immediate Cause (Final disease or condition | Blunt force | e injurie | s of | head wit | th com | mlicati | one | | Interval Between Onset and Death |
| 1 | /Medical Examiner | | resulting in death) | Due to (or as a co | ensequence of): | | | ch con | рттеас | LUIIS | | |
| | 1. 53.4 | 5 | Sequentially list conditions, | b. — Due to /es ee e e | | | | | | | | |
| | uted 1 Insit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co | insequence or): | | | | | | | |
| oʻ | be executed sicien and burial-transit | Exa | that initiated events resulting in death) Last | c. Due to (or as a co | nsequence of): | | | | | _ | | |
| 8760, | # × 6 | lical | (| d | | | | | | | | |
| 9 | leath certifica ettending ph I for use as th | Med | IF FEMALE: | | | | | | | | | |
| Box | death ce | an/l | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pr | | Ectonic | pregnancy | | | 1 | 23d. Date of deli | very |
| | 0 0 0 | Physician/Med | 1 Yes 2 No | 4□Pregnant at time 9□ Unknown | | Other (s | | | | | Month | Day Year |
| P.0 | equires thet the de sen signed by the e tould be detached t | A. | Part II. Other significant conditions | contributing to death but no | at reculting in the un | oloub do - | | | T | | | |
| of Vital Records, | uires sign ld be | | | de la constant de la | r resulting in the un | denying | cause given in Part | (- | | | | the cause of death? |
| S | ~ ~ ~ | lete | | | | | | | 1 🗆 Ye | | | bably 4 Unknown |
| Re | The la | Completed | | | | | | | 24a. Was a autops | У | 24b. Were aut | opsy findings available omptetion of cause of |
| ita | hysicien: The law his certificate has b I director, paga 2 s | 0 | 25. Was case referred to medical | | | | | | Yes 2 | □ No | death? | 2 🗆 No |
| _ | Physicien: this certificant | 10 B | examiner? 1 □XYes 2 □ No | Hospital: | 2 ER/Outpatient | 3□ D | 0+ | | (Check only on | | i □Other (Spec | |
| Ē | Jing Pl h. After ti funera | | 27. Manner of Death 1 □ Natural 5 □ Pending | 28a. Date of Injury (Month, Day Yea | 28b. Time of | | 28c. Injury at Work? | | Bd. Describe ho | | | (hy) |
| sio | Attending r death. octor: After by the fune | cati | 2 Accident investigation 3 Suicide 6 Could not b | 9-2-01 | 3:17 | A | 1 ☐ Yes 2 💢 | INO S | ubject | bea | ten | |
| Division | or At offer of Direct in by | Certification; | 4 M Homicide determined | 28e. Place of Injury - building, etc. (S) | At home, farm, stre | et, factor | y, office | 28 | If. Location (Str. City or Town | eet and | Number or Run | al Route Number, |
| | ours cours filled | 2 | 29a. Certifier 1 Certifying Ph | Found on s | street | | | S | | | | lk. E. Eager |
| | To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th gompletely filled in by the funeral | Medical | (Check only one) | ysician: To the best of my niner: On the basis of exa- and manner stated. | Knowledge, death mination and/or inve | occurred estigation | dat the time, date ar n, in my opinion, dea | nd place, ar ath occurred | nd due to the ca | use(s) te and | and manner as : place, and due ! | stated. |
| | within To th | 3 | 29b. Signature and title of certifier | A | | | c. License number | | | | signed (Month, | |
| | 1 Olen | | 1 Carle | MU) | | | O.C.M.E. | | 1 | | BER 23, | ,, , |
| . (| 0r'/ | | 30 Name and address of person who | completed cause of death | (Item 23a) (Type, P | rint) | | | | | | |
| 1 | | | 1. Utkrini 404 | CE (M) | | 111 | PENN STRE | EET BA | LTIMORE | MA | RYLAND : | 21201 |
| | Stat Registra | - | 31. Date filed (Month, Day, Year) | 32 Registrar's S | ignature doe | de | | | | | | |

| | | | 1 For State | State of Maryl | | | | Mental Hygi | ene | 00010 |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|-------------------------------------------|---------------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Las | *** | | ertificate | of Death | 2. Date of Death | a. Mc. UU5 | 38012 |
| | Physici /Medi | | | Norris A | . Dicke | erson | | November | Day Year | |
| | Examir | | 4a. Facility Name (If not institution, give | NI | | 4b. City, T | wn, or Location of De | | 4c. County of Dea | |
| | | ш | 5. Social Security Number 6. Se | wheare | yrs. last birtho | Ball fav) If Under 1 | MOU M. Year If Under 24 H | | | ltimore |
| | Funeral Director | | | 2 F 7. Age (///) | 86 Yrs | Months | Days Hours Mi | | | thplace (State or Foreign buntry) Marvland |
| | pu . | | Usual Residence of Decedent 10a. State 10b. County | 100 | . City, Town o | y Logotion | | 7 dg 20, | 1010 | |
| | death with the Maryland me 23a or 28a-f show Imust be notified at | Ď | , | I/A | . Only, TOWATE | Location | Baltimore | | | 10d. Inside City Limits 1 Yes 2 No |
| | th the or 28a or 28a | Funeral Director | 10e. Street and Number | | | 10f. Zip C | | 10 | g. Citizen of What Co | ountry? |
| | ath wi | ral | 201 North Monastery Av | | | | 21229 | | U.8 | S.A. |
| | ter de | nue | 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever i | n U.S. | Was Decede If Yes, specif | nt of Hispanic Origin? y Cuban, Mexican, Pue | (Specify Yes or No- erto Rican, etc.) | 14. Race - Ame Black, Whit | |
| 960 | 2-0030 72 hours after natural; or its | by | 3 Widowed 4 Divorced | 1 □Yes 2 □ No If Yes, Give Year or Dates: | 1943 1944 | 1 ☐ Yes 2 | No Specify: | | Specify: | Black |
| Ti C | 72 hc | Completed | 15. Decedent's Edi (Specify only highest grad | | 16a. D | ecedent's Usual Give kind of work | Occupation done during most of w retired) | orking 1 | 6b. Kind of Business | /Industry |
| Š | withir than the within | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) | 16 | te. DO NOT use | Minister | | Ch | urch |
| 7 | e filed al Hyg lother | BeC | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's N | ame (First, Middle, Ma | aiden Sumame) | |
| 3 | aryidilid 2.12.1 should be filed within nd Mental Hygiene. marked other than " umatic event, the Me | To | | Dickerson | | | | | ie Corvin | |
| Š | diffiliote, indifficial A 12.15-0030 mit. Pages 1 and 2 should be filed within 72 hours att periment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural; or y Injury or other traumatic event, the Medical Exam. | | 19a. Informant's Name/Relationship (T) Martha Dickerson Wife | ype, Print) | 19b. M | | Street and Number or I | | | |
| 9 | ite, IV | | 20a. Method of Disposition | | b. Place of D | isposition (Name crematory or oth | of | | Oc. Location - City or | |
| | Page Page ment c ant: # ury or | | 1 Burial 2 □ Cremation 3 □ I Donation 5 □ Other (Specify) | | • | • | erans Cemetery | 11/30/05 | Owings | Mills, Md. |
| *** | Definition (e), Interly leating A. I.A. 13-0030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Deperment of Heath, and Mantal Hygiene. Important: if item 27 is marked other than "natural, or iteme 23s or 28s-f show any higher other traumatic event, the Madical Examinational Denotitied at once. | | 21. Signature of Funeral Sergice Licens | ee , G | - 2 | | Address of Facility | noral Cantina D | Λ. | |
| | | | 23a. Part1. Enter the disease, or comp | lications that caused the d | leath. Do not | 130 | ep Brothers Ful 00 Eutaw Place | Baltimore, Md 2 | 21217 | Approximate |
| | Physician | | shock, or heart failure. List only of Immediate Cause (Final disease or condition | ne cause on each line. | 07.500 | | ,g, | as or roopilatory arros | , | Interval Between Onset and Death |
| | /Medical | | resulting in death) | a. Due to (or as a con | sequence of): | | | | | 12 WS |
| | Examiner | 7.0 | Sequentially list conditions, | . Woend | sequence of): | farctn | m | | | 24 hrs |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a con | sequence on, | | | | | |
| c | ate be executed thysician and the burial-transit | Exa | resulting in death) Last | Due to (or as a con | sequence of): | | | | | |
| 0320 | 2 to 2 to 2 | dical | (| d | | | | | | |
| 200 | 2 00 % | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pre | gnancy | | | | 22d Pate of del | |
| à | the ette | sicla | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown | | 3 Ectopic preg 5 Other (spec | | | 23d. Date of del Month | Day Year |
| | d by the | Phy | 9 Unknown | | | | | | | |
| Dickuson, Norris | vequires that the death | Completed by | Part II. Other significant conditions co | atual libi | NI | onderlying cau | se given in Part I. | | cco use contribute to | the cause of death? |
| Jor 1 | as been 2 should | lete | | | ., | 1 | | 24a. Was an | | topsy findings available |
| ~ 0 | The lav | mo: | | | · · · · · · · · · · · · · · · · · · · | | | autopsy performe | prior to death? | completion of cause of |
| ickuson, | Attending Physician: The Tadadh. ctor: After this certificate hay the funeral director, page | Be | 25. Was case referred to medical examiner? | | | | | eath (Check only one) | | 2 140 |
| 3 | ding Phys | To | 1 Yes 2 No | | 2 ER/Outpa 28b. Tim | | | Home 5 Residen | | city) |
| 2 5 | nding ath. r: Afte e fune | atlor | 1. Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year | r) Inju | M Z | : Injury at Work? 1 ☐ Yes 2 ☐ No | 200. Describe now | injury occurred | |
| A | or Attend ter death irector: / | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - A building, etc. (Spe | t home, farm, | , street, factory, o | office | 28f. Location (Stre City or Town, | et and Number or Ru State) | ıral Route Number. |
| ' ' | pital o | Ce | 29a. Certifier 17 Certifying Phy | niciana Taraha harakatan | | | | | | |
| | To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the | Medical | (Check only one) | sician: To the best of my ner: On the basis of exam and manner stated. | knowledge, d lination and/o | eath occurred at r investigation, ir | the time, date and place my opinion, death occ | e, and due to the cau curred at the time, date | se(s) and manner as and place, and due | stated. to the cause(s) |
| | To th withir To th | Me | 29b. Signature and title of certifier | 2 | | 29c. t | icense number | 290 | I. Date signed (Monti | o, Day, Year) |
| | . [| 2 | Vay M Vip | hirston | | P | 1700Ce | 1 | lovember | 22 2005 |
| | HI | | 30. Name and address of person who co | ompleted cause of death (| Item 23a) (Ty | pe, Print) | - Ra | Ofinino | lovember | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's Si | gnature £ | 714)0 | 1 th | MINUL | x, 1119 | - 1 |
| | Registr | ar | NOV 2 | 8 2005 Danie | 40 10 | STATE OF | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10a per inf g850 12-1-05 yt

| | | | 1 = State Registrar | state of Man | | artment of H rtificate of I | | | ene 3. No. | |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------|-------------------------------------------------------|------------------------------------------------|
| | Physici /Medic | _ | 1. Decedent's Name (First, Middle, Last) Thomas Joseph E11woo | od | | | | 2. Date of Death Month November | Day Quanto | STIP Posting |
| | Examin Funeral Director | | 4a. Facility Name (If not institution, give street Peninsula Regional 5. Sociat Security Number 6. Sex 11 M M | Medical | Center n yrs. last birthday) 66 Yrs. | 4b. City, Town, or Salis If Under 1 Year Months Days | tf Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Y March 22 | 4c. County of Death 4c. Com i 9. Birtl Co 1939 Ms | |
| | D | ŗ. | Usual Residence of Decedent 10a. State Delaware Haryland Sussex | 10 | Cc. City, Town or Lo | | | rial CII 22 | , 1939 Fi | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | 3a or 28a-f | Funerai Directo | 10e. Street and Number 5 Teaberry Cir. | | Tellwich | 10f. Zip Code 19975 | | | g. Citizen of What Co United Sta | untry? |
| 336 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if Item 27 is marked other then *naturel', or Iteme 23e or 28e-f ehow mortants if Item 27 is marked other then *naturel', or Iteme 23e or 28e-f ehow apply follory or other treumatic event, the Madical Examinat must be notified at page. | by Funera | · | Was Decedent Eve Armed Forces? 1 XXYes 2 □ No tf Yes, Give Year or Dates: 19 | | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ሺ No | ispanic Origin? (Sp in, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Ame Black, White Specify: Wh | e, etc. |
| Maryland 21215-0036 | within 72 hou ane. then *nature be Medical E | Completed | 15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12) | ion | 16a. Dece (Give life. | dent's Usual Occupi kind of work done o DO NOT use retired | ation during most of work t) | ing | 6b. Kind of Business/ | ndustry e, insurance |
| land 2 | uld be filed v Vental Hygie irked other i itlc event, | Be | 17. Father's Name (First, Middle, Last) Stephen C. Ellwood | | D | LORGE | | e (First, Middle, Ma | | ; Insulance |
| | and 2 sho ealth and t m 27 is ma | | 19a. Informant's Name/Relationship <i>(Type</i> Mary Michelle Ellwoo | od/wife | 5 Te | aberry Ci | r. Fenv | vick Isla | | 975 |
| Baltimore, | t. Pages 1 rtment of H rtant: If Ite | | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify) | ioval iloini State | Greenmour | osttion (Name of matory or other place of cremato | ory Nov. 2 | 25,2005 B | altimore, | Maryland |
| Bal | Dermi Depa Impo | | 21. Signature of Funeral Service Licensee 23. Part 1. Enter the disease, or complica | Rell IX | | 0000 1 | ork ka. | ватиллю | | Inc. 212 Approximate |
| | Physician /Medical | | mock, or heart failure. List only one tmmediate Cause (Finat disease or condition resulting in death) | cause on each line. | | e trunc | | | | Interval Between Onset and Death |
| | Examiner | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Mo- | | le Acci | dent | | | |
| ,0928 | cate be executed physicien and the burial-transit | dicai Exa | that initiated events resulting in death) Last | Due to (or as a co | onsequence of): | | | | | |
| .O. Box 6 | death certiff e attending ed for use as | Physician/Med | tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | If yes, outcome of p 1 Live birth 2 = 4 Pregnant at time 9 Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of deli Month | very Day Year |
| S, D | w requires thet the been signed by th should be deteche | þ | Part II. Other significant conditions contri | outing to death but n | ot resulting in the u | nderlying cause give | en in Part I. | 23e. Did toba | cco use contribute to | the cause of death? |
| al Record | The lew ate hes b pege 2 sl | Completed | or W. | | | | | | prior to death? | topsy findings available ompletion of cause of |
| Vital | | o Be | 25. Was case referred to medical examiner? 1 Pres 2 No | pitat: | 2 PER/Outpatier | nt 3 DOA Othe | ar | n <i>(Check only one)</i> me 5 □ Residend | ce 6 □Other (Spec | 26.1 |
| Division of | ding After fune | ertification: T | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | 28a. Date of tnjury (Month, Day Ye | 28b. Time o | f 28c. Injun Wan | yat ⟨? Yes 2 ⊉No | 28d. Describe how | intury occurred | |
| Divi | To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: ⊬ completely filled in by the fi | O | 4 Homicide determined 29a. Certifier 1 Certifying Physic | 28e. Place of Injury building, etc. (5 | Specify) | | | RT 50 / | Tilgman + | Rd Salisby |
| | the Ho hin 24 h the Fui npletely | ledicai | (Check only 2 Medical Examine one) | r: On the basis of exa and manner stated | amination and/or in | vestigation, in my or | pinion, death occurr | ed at the time, date | e and place, and due | to the cause(s) |
| | To the within To the compl | M | (mon) | DME | | 29c. License | | 29d | Date signed (Month | , Day, Year) |
| 1 | 20 | | C1 | oteted cause of death | | | + Salie | share ! | no 218 | 801 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 8 2005 | 32 Registrar's | Signature | is some some | · · · · | wig 11 | W 5/10 | <i>v.</i> |

CPM 05-07884 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tony Edwards State of Maryland / Department of Health and Mental Hygiene G850 12-7-05 tas
Registrar Registrar nt's Name (First, Middle, Last) 2. Date of Death **Physician** Edwards 2005 November 14:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University Hospital-Shock Trauma Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day. **Funeral** 9. Birthplace (State or Foreign Days M 2 F a 215-15-1509 Director Yrs. land Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö rai', or itema 23a or Examinar must be USA Dad 39 by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 2 100 Specify: 3 ☐ Widowed 4 ☐ Divorced natural Completed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry econdary (0-12) College (1-4or 5+) 17 is marked other Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town (Mother) Health em 27 20c. Location - City o item 2 itoinet te 20a. Method of Disposition Burial 2 □ Cremation 3 | Removal from State Depertment of Important: If any injury or once. ☐Donation 5☐Other (Specify) 21. Signatury of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Gunshot wound of head with complications /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (c) as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Š Completed 1 ☐ Yes 2 🗆 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of cause of 24a. Was an page 2 s autopsy performed? certificate Yes 2 No 2□ No director 25. Was case referred to medical examiner? To Be 26. Place of Death (Creck only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA his funeral 27. Manner of Death Date of Injury (Month, Day 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred **Division** 5 Pending investigation 1 Natural Injun death. \mathbf{P}^{M} 1 ☐ Yes av No filled in by the 2 Accident 11-20-05 8:52 Subject shot 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rusal Route Number. City or Town, State) 5100 blk. Hillen Rd. Street Baltimore, within 24 hours a To the Funeral I completely filled 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32. R

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

November 23, 2005

| | | | 1 - For State Registrar | State of Mar | | artment of rtificate of | | d Mental Hy | giene 05 | 38015 |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------|----------------------------------------------|-----------------------------------------------------|
| | 9. H | | Decedent's Name (First, Middle, La. | st) | | | | 2. Date of De | eath | 3. Time of Death |
| | Physici /Medi | | Samuel B. | Fad | es. II | | | Novem | Day Yes ber 23, 20 | 05 9:11 a ^M |
| | Examir | | 4a. Facility Name (If not institution, giv | a street and number) | , | 4b. City, Town, | or Location of D | | 4c. County of D | |
| | | | 24 Crafton Road | | | Essex | | | Baltimo | re |
| | Funeral | | 5. Social Security Number 6. S | | In yrs. last birthday) | If Under 1 Yea Months Day | | Hrs. 8. Date of Bin. (Month, Da | th 9.1 | Birthplace (State or Foreign |
| | Director | | 212 40 10// | O(M 2□ F 6 | 3 Yrs. | World Day | 110013 | 12-03- | 1941 | MARYLAND |
| | and * | | Usual Residence of Decedent 10a. State 10b. County | 1 | Oc. City, Town or Lo | ncation | | | | 104 1-14-03-11-3- |
| | e Maryla Sa-f sho | ctor | MD. BALTI | | | | SEX | | | 10d. Inside City Limits 1 ☐ Yes 2 🛣 🔥 o |
| | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other then "natural", or iteme 23a or 28a-f show or other treumatic event, the Madical Examinar must be notified at | Funeral Director | 10e. Street and Number 24 CRAFTON | ROAD | | 10f. Zip Code 21 | 221 | | 10g. Citizen of What U. S. | |
| | dea | ner | 11. Marital Status | 12. Was Decedent Ev Armed Forces? | er in U.S. 13. | Was Decedent of | Hispanic Origin? | (Specify Yes or No Jerto Rican, etc.) | 14. Race - A | merican Indian, |
| 9 | or its | F | XX Never Married 2 Married | XXYes 2 □ No IVes, Give | 1963- | 1 ☐ Yes XX N | | Jerto Rican, etc.) | | |
| 93 | ours | d by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | 1991 | 1 - 102 VA | з эрөспу. | | Specify: | WHITE |
| 21215-0036 | 72 h | Completed | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | (Give | dent's Usual Occi | a during most of | working | 16b. Kind of Busine | ss/Industry |
| 2 | within ene. then " | mpi | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | CLERICAL | ed) | | BETHLEHEM | 1 STEEL |
| | filed v Hygie other t | | 17. Father's Name (First, Middle, Last) | 4 YEARS | | CLLRICA | | | | |
| anc | ould be fi Mental H arked ot atic ever | Be | | ADES | | | | Name (First, Middle | | 1 |
| 3 | should ind Man in marke | To | | | | | 1 | NERVA E. | | |
| Maryland | 12 sho h and 7 Is mu | | 19a. Informant's Name/Relationship (1 SANDRA L. EADES | (SISTER) | | | | | er, City or Town, State | |
| | 1 and lealt | | 20a. Method of Disposition | (3131LK) | 20b. Place of Dispo | | - KIDGE | Date Date | | AND, 21013 |
| Baltimore, | toff iffice | | XX Burial 2 Cremation 3 | | cemetery, crea | matory or other pla | | | 20c. Location - City | |
| ţï | t. Part tant njury | | 4 □Donation 5 □Other (Specify | | HIGHVIEW | | - 1111 | -29-2005 | BEL AIR, | MARYLAND |
| Bal | permit. Pag Department Important: f eny injury o | | 21. Signature of Funeral Service Licen | | DUTILL | 2. Name and Addi UCK TOWS | | al Home, | 1050 Inc. Towso | York Road n.Md.21204 |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | olications that caused the | | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Card | un out | | ares | Carro | + | Onset and Death |
| * | /Medical | | resulting in death) | Due to (or as a c | onsequence of): | oraco n | 2009 | arre | Cun | mediat |
| | Examiner | | Cognestially list conditions | , Ang | mia | | 1 | | | |
| | D = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | onsequence of): | | | | | |
| | ate be executed hysicien and the burial-transit | Examiner | lial illicated events | c. 1 CV | wles. | ferol | | | | |
| Ó, | e exe ien a urial- | EX | resulting in death) Last | Due to (or as a c | onsequence of): | | | | | |
| 8760, | cate be exphysicien the buria | dicai | | d. Hy per | teusi | m | | | | |
| 99 | ndiffica ng pl | Med | IF FEMALE: | | | | | | | |
| Вох | eath certific attending p for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 ☐ Live birth 2 [| | Ectopic pregnanc | ev | | 23d. Date of d | |
| . E | e dea | sici | 1 ☐ Yes 2 ☐ No | 4☐Pregnant at tim 9☐ Unknown | | Other (specify) | | | Month | Day Year |
| P.0 | that the de led by the detached | P. | 9 Unknown | 7.1 - 101 | | | | | | |
| Ś | 88 50 60 | þ | Part II. Other significant conditions of | ontributing to death but r | not resulting in the u | nderlying cause g | ven in Part I. | 23e. Did to | obacco use contribute | to the cause of death? |
| Records, | w require been si should I | Completed | | -0 | | | | 10` | res 2,25 No 3□ | Probably 4 Unknown |
| Ö | e law I hes bo | pie | | | | | | 24a. Was | an 24b. Were | autopsy findings available o completion of cause of |
| E | | No. | | | | | | | rmed? death | ? |
| of Vital | Physician: r this certific ral director, | Be (| 25. Was case referred to medical examiner? | | | | 26. Place of D | Death (Check only o | - | - |
| Ž | hysic his co | 2 | 1 ☐ Yes 2 No | Hospital: 1 Inpatient | 2 ER/Outpatien | t 3 DOA | her: 4 🗆 Nursing | Home 5 Resid | dence 6 □Other (Sp | pecify) |
| | ng P fter t inera | Ë, | 27. Manner of Death Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Y | 28b. Time of Injury | 28c. Inju | iry at | 28d. Describe h | now injury occurred | |
| Sio | endi eath. or: A he fu | ati | 2 ☐ Accident investigation | 1 1 / / - | | | Yes 2 □No | | | |
| Division | I or Attendi after death. Director: A I in by the fu | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. (| - At home, farm, str Specify) | eet, factory, office | | 28f. Location (S City or Tow | Street and Number or | Rural Route Number, |
| | ital or raf Draft India | | | | | | | | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune | Medical | 29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam | ysician: To the best of n iner: On the basis of ex and manner stated | amination and/or inv | occurred at the treatment occurred at the treatment of th | ime, date and pla opinion, death oc | ce, and due to the courred at the time, | cause(s) and manner date and place, and d | as stated. ue to the cause(s) |
| | o the | ∑ E | 29b. Signature and title of certifie | 2.13 | | 29c. Licen | se number | | 29d. Date signed (Mo | nth. Dav. Year! |
| | ->-0 | | 1 Atallan | MA | | | | | 11/2-1 | |
| | At I | | 30. Name and address of person who d | completed cause of day | h (Itom 22+) (Terr | D14 | | 16.00 | 11/23/0 |)_> |
| - 1 | 0,4 | | 3346 Pa | per Mill | R (Item 23a) (Type, | | ket his | MO | 21131 | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 1 | | | · · · × | | -1131 | |
| 3 | Registr | | NOV 2 8 200 | 5 Denos | Signature | Sis. | | | | |

| | | | State of Maryland / Department of Health a 1- For State Registrer Certificate of Death | | ntal Hyg | piene n n 5 | 38016 |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------|-------------------------------|---------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Date of Deat | leg. No. | |
| | Physici | an | | | | 26 2005 e | 3. Time of Death |
| | /Medio | | Lillian A. Francis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location o | | lov. 2 | 1 | 5:55AM |
| | Examir | er | EastpointRehab&NursingCenter Baltimore | | | 4c. County of D | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 | 2111 | Date of Birth | | |
| | Director | | 218-01-1037 1 M 2F 95 Yrs. Months Days Hours | Min. | (Month, Day, | | Birthplace (State or Foreign Country) |
| | ס | | Usual Residence of Decedent | 1 1 1 1 1 1 | larcii | 10,1910 | MAryland |
| | nylan | | 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits |
| | Ba-f s | cto | MD Baltimore Middle Rive | r | | | 1 ☐ Yes 21 No |
| | or 2 | Director | 10e. Street and Number 10f. Zip Code | | 1 | 0g. Citizen of What | Country? |
| | s 23s | ra. | 7116 Olivia Road 21220 | | | USA | |
| | er de Items | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican, | igin? (Specify n, Puerto Rica | y Yes or No- an, etc.) | 14. Race - A Black, W | merican Indian, hite, etc. |
| 36 | rs aft | by F | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates: | | | Specify Wh | ite |
| Ö | tura stura | edl | 15. Decedent's Education 16a. Decedent's Usual Occupation | | | 16b. Kind of Busine | |
| 15 | n "ne | Completed | (Specify only highest grade completed) (Give kind of work done during most | t of working | i_ | | , |
| 212 | d with giene ir tha | E O | Elementary/Secondary (0-12) College (1-4or 5+) Cashier | | 1 | vepartme | ent Store |
| Þ | be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23e or 28e-f show event, the Mcdiral Examiner must be notified at | Be C | | er's Name (Fi | irst, Middle, M | Maiden Surname) | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. | ToE | | known | | | |
| Nar | and 2 sh ealth and n 27 is m | | 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number</i>) | | | | |
| ė, | es 1 and 2 of Health item 27 i | | Andrea Whitcomb/daughter 1401C.Bonnett P. 20a. Method of Disposition (Name of | Date | | | |
| ō | Pages nent of int: if it | | 1 ➡Burial 2 □Cremation 3 □Removal from State cemetery, crematory or other place) | 11/ვე | | 20c. Location - City Baltimo | |
| Ħ | artme ortani injury | | 1. Signatury of Funeral Service License | | | | |
| B | permit. Departr Imports any inju | | R. Terry Connelly 300 Mace AV | Coni | _ | | lomeofEssex |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. | cardiac or re | spiratory arre | est, | Approximate |
| | Pnysician | | Immediate Cause (Final disease or condition resulting in death) a. Atheroscleratic Carchio Va | | | | Interval Between Onset and Death |
| | /Medical | | resulting in death) Due to (or as a consequence of): | 15000 | Q P | DIZERIE | |
| | Examiner | | Sequentially list conditions, b. | | | | |
| | sit sit | Examiner | if any, fauling to immadate cause. Enter funderlying Cause, Disease or injury | | | | |
| | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | хаш | resulting in death) Last Due to (or as a consequence of): | | | | |
| 8760, | icate be ex physician the buria | E E | Sub to (or as a consequence of). | | | | |
| 387 | phys phys the | dical | d | | | | |
| 9 X | death certific attending p | /Me | IF FEMALE: 23c. If yes, outcome of pregnancy | | | 2015 | |
| Вох | atter for u | Physician/M | in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy | | | 23d. Date of d | lelivery Day Year |
| o | that the deed by the a | ysi | 1 UYes 2 No 9 Unknown 9 Unknown | | | | |
| α_ | res that igned b be deta | by Pr | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tob | acco use contribute | to the cause of death? |
| Records, | quires n sign | q p | | | 1 🗀 Ye | s 2 No 3 | Probably 4 @Unknown |
| 00 | w requires been significant to the second bloom of the second bloo | Completed | | | 24a. Was an | 24h Were | autopsy findings available |
| | The lav ate has page 2: | mo | | | autopsy | y prior to ned? death? | completion of cause of |
| Vita | | a | 25. Was case referred to medical | | | ±2No 1 □ Ye | es 2□No |
| > | ysician: is certific director, | To B | examiner? | | heck on , one 5 □ Basider | nce 6 ∐Other (Sp | |
| 0 | g Ph er thi | | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at | 7 | | w injury occurred | (өспу) |
| 0 | death. ctor: After y the funera | atlo | 11⊠Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 N | No | | | |
| Division of | after deatl | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. l | Location (Str. City or Town, | reet and Number or i | Rural Route Number, |
| ٥ | tal or A | Cer | bullding, s.c. (opecity) | | City of TOWIT, | , 3(4(9) | |
| | Hospi 4 hour Funer sely fill | | 29a. Certifier (Check only only only only only only only only | d place, and o | due to the car | use(s) and manner a | as stated. |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. | Medical | and manner stated. | | | | |
| | K 3 F 8 | | Discourse in the second | | 23 | L. Dato Signed (MO) | locar, real) |
| 0 | 7 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |) | | 11178 | 105 205 212 51 |
|) | | | TARIO MAHMOUD 201-109 Back River | No. | 1- R | Percel T | Sathing |
| | Sta | te . | 31. Date filed (Month, Day, Year) 32. Refistrar's Signature, | | - (C | | S TORE |
| | Registr | ar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MALMOUD 201-109 Back (River 31. Date filed (Month, Day, Year) NOV 2 8 2005 | | | | |

| | | | 1 - For State Registrar | | | artment of Health and I rtificate of Death | Mental Hygien | DOOF O | 8017 |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------|
| | Physici /Medi | cal | 1. Decedent's Name (First, Middle, Las | L. F | REL | EMAN | 2. Date of Death Month D | 24, 2005 | Time of Death 7:53 Am |
| | Examir | ier | 4a. Facility Name (If not institution, give CARROLL HOSPIT 5. Social Security Number 6. Se | 'AL CENTER | A for Smith admin. 1 | 4b. City, Town, or Location of Death WESTMINSTER If Under 1 Year If Under 24 Hrs. | | c. County of Death CARROLL | |
| | Funeral Director | | | 7. Age (In yrs. lass | Yrs. | Months Days Hours Min. | 8. Date of Birth (Month, Day, Year 12/4/1920 | (Country) | (State or Foreign |
| | with the Maryland a or 28a-f ehow | Director | MD 10b. County MONTGOM | ERY P | FOWN OF LO | | | | Inside City Limits |
| | th with the 23s or 2 | | 10e. Street and Number 11719 ENID DR. | | | 10f. Zip Code 20854 | 10g. C | itizen of What Country? | |
| 920 | within 72 hours after deeth with the Maryland ene. then "neturel", or items 23e or 28e-1 ehow ta Mailcal Examiner mast be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: | i i | Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert I ☐ Yes 2 ☒ No Specify: | pecify Yes or No- o Rican, etc.) | 14. Race - American Ir Black, White, etc. Specify: WHITI | · |
| 21215-0036 | TO TO 는 - | Completed | 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) | ucation 1 de completed) College (1-4or 5+) | (Give | lent's Usual Occupation kind of work done during most of wor DO NOT use retired) HOUSEWIFE | King | Kind of Business/Industr | у |
| Maryland ; | should be filed ind Mental Hygi markad other umatic event, II | To Be C | | RISON B. OXLE | | MA | ne (First, Middle, Maide, ARY LUCINI | DA BERRY | |
| | t and 2 Health a em 27 is | | 19a. Informant's Name/Relationship (T) CAROL ANN GAVIN 20a. Method of Disposition | - DAUGHTER | 4550 e of Dispo | sition (Name of | PT.305,OW | INGS MILL | S, MD |
| Baltimore, | Page nent o ant: If ary or | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeration Service License | 7 | | Y CREMATION 11 | /25/05 SY | KESVILLE, | MD. |
| Ba | permit. Departr Imports any inje | | N Jany 1/2 | eltyle | 2. | Name and Address of Facility FL 54 E. MAIN ST. | , WESTMIN | | E 21157 |
| 100 | Pnysician /Medical | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) | ilications that caused the death. (ine cause on each line. PNEUMON Due to (or as a consequen | IA | er the mode of dying, such as cardiac | or respiratory arrest, | Inte | proximate prval Between set and Death |
| | Examiner | niner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or linjury | b. Due to (or as a consequen- | ce of): | | | | |
| 8760, | cate be executed physicien and the burial-transit | dicai Examine | that initiated events resulting in death) Last | c | ce of): | | | | 1 |
| P.O. Box 68 | the death certifii y the attending p iched for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de. 4 □ Pregnant at time of death 9 □ Unknown | ath 3 🗆 | Ectopic pregnancy Other (specify) | | 23d. Date of delivery Month Day | Year |
| | The law requires that ite has been signed b page 2 should be deta | ed by Pl | Part II. Other significant conditions co | ntributing to death but not resultin | ng in the un | derlying cause given in Part I. | 23e. Did tobacco 1 ☐ Yes 2 | use contribute to the cat | use of death? |
| Vital Records, | | Completed by | | | | | 24a. Was an autopsy performed? | 24b. Were autopsy fi prior to complete death? 1 🗆 Yes 2 🗀 | ion of cause of |
| Z. | ysician; is certific director, | o Be | 25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 | Hospital: 1 Inpatient 2 ☐ ER/ | /Outnation | Other | th (Check only one) ome 5 Residence | 0 17015 - 1/2 - 1/1 | |
| Division of | ding Ph n. After th funeral | atlon; T | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | | b. Time of Injury | 28c. Injury at Work? M 1 Yes 2 No | 28d. Describe how inju | | |
| Divis | Diri | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At home building, etc. (Specify) | | | City or Town, State | | ite Number, |
| | ne Hospital n 24 hours a ne Funaral i | Medical | 29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exemi | sicien: To the best of my knowled ner: On the basis of examination and manner stated. | dge, death and/or inv | occurred at the time, date and place, estigation, in my opinion, death occur | and due to the cause(s red at the time, date and | and manner as stated. I place, and due to the c | cause(s) |
|) | To the To the Complet | W | 29b. Signature and title of certifier | ar, M.J. | | 29c. License number DOO 17695 Print) ROLL HESPITAL CE | 29d. Da | te signed (Month, Day, | Year) 2005 |
| 0 | V | | | pmpleted cause of death (Item 23: | a) (Type, F | Print) ROLL HESPITAL CE | ENTER , WEG | memoren MINSTER, A | ND 21157 |
| | Sta Registr | _ | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | 4 | South 9 | | · · · · · · · · · · · · · · · · · · · | |

| | | | 1 - State Registrar | State of Maryland | | rtment of F | | Mental Hygier | 2005 | 38018 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------|----------------------------------------------------|
| 34. | Physici /Medic | | Decedent's Name (First, Middle, Last) | Crah | Ĭ4 | | | 2. Date of Death | Day 4 Year | 3. Time of Death |
| | Examir Funeral Director | | 5. Social Security Number 6. Sex | 7. Age (In yrs. In | ast birthday) Yrs. | 4b Sity, Town, o | If Under 24 Hrs. Hours Min. | 8. Date of Birth | 9. Birt | hplace (State or Foreign unitry) |
| V | D | | Usual Residence of Decedent 10a. State 10b. County | 80 | , Town or Lo | cation | | 1 12 2 | Mar | yland 10d. Inside City Limits |
| | the Mary 28a-f ah | ector | MD Baltime | ore | Reis | terstown | | 100 | Citizen of What Co | 1 Yes 2 No |
| | With Sa or | ā | | | | | 126 | l log. | | unity : |
| | ns 23 | era | 27 Glyndon Drive | 12. Was Decedent Ever in U.S | S. 13. V | | 136 lispanic Origin? (So | ecity Yes or No- | USA 14. Race - Ame | rican Indian |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow amy injury or other traumatic event, the Medical Examinar must be notified at QDCs. | by Funeral Director | 1 Never Married 21 Married 3 Widowed 4 Divorced | Armed Forces? t | 1 | Yes, specify Cuba | lispanic Origin? (Sp an, Mexican, Puerto Specify: | Rican, etc.) | Black, White | e, etc. |
| Maryland 21215-0036 | hin 72 ho a. an "naturi Medical i | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | | (Give | ent's Usual Occup kind of work done OO NOT use retired | during most of work | ing 16b. | Kind of Business/ | Industry |
| 7 | d wit | , or | 12 | 0 | maı | nager | | | grocery | store |
| g | al Hy othe | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | e (First, Middle, Maid | | .,, |
| <u> a</u> | uld b Wentz rrked | 70 E | William R. Greeby | Jr | | | Mabe] | l Pearl Ba | ndz | |
| ar | and l | | 19a. Informant's Name/Relationship (Ty) | | 19b. Mailin | g Address (Street | and Number or Rur | al Route Number, Cit | y or Town, State, 2 | Tip Code) |
| Σ | and 2 palith n 27 l | | Rebecca Greeby/spo | ouse | 100 (| Greenway | #217 Peri | yville, M | D 21903 | |
| Baltimore, | Pages 1 nent of He ant: If iten ary or oth | | 20a. Method of Disposition 1 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) | emoval from State | ace of Dispo emetery, cren | sition (Name of natory or other place | (a) | Date 20c. | Location - City or | Town, State |
| Balt | permit. Departr Importe any inju | | 21 Signature of Funeral Service License Ronald S. W | ide Vicector | S | | omy Board | 1 655 W. Ba | altimore | Street |
| | Physician /Medical Examiner | 1 | 23a. Pail 1. Enter the distase, or complishon, or heart faill re. List only on Immediat Lause (Final disease or condition resulting in death) | chirs that caused the death le cause on each line. Due to (or as a consequ | Cun | er the mode of dyin | g, such as cardiac | or respiratory arrest, | | Approximate Interval Between Ons I and Death |
| 8760, | icate be executed physician and s the burial-transit | dicai Examiner | Sequentially list conditions. Tary, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequ | | | | | | |
| .O. Box 6 | The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as | Physiclan/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of defi Month | very Day Year |
| S, D | iw requires that s been signed b should be deta | þ | Part II. Other significant conditions con | ntributing to death but not resu | Iting in the ur | derlying cause giv | en in Part I. | 23e. Did tobacc | | the cause of death? |
| Vital Record | The law rec te has bee age 2 shoi | Completed | 0 | | | | | 24a. Was an autopsy performed | prior to death? | topsy findings available completion of cause of |
| ta | an: tifica for. p | a) | 25. Was case referred to medical | | | | 26 Place of Death | 1 Yes 2 1 | Vo 1 ☐ Yes | 2□ No |
| <u>=</u> | Attending Physician: r death. ector: After this certifica | To B | examiner? | iospital: 1 Inpatient 2 E | B/Outnatien | 3 DOA Oth | 00 | me 5 Residence | 6 Other (See | 2541 |
| ō | g Phy eral | | 27. Manner of Death | - | 28b. Time of | 28c. Injun Worl | THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW | 28d. Describe how in | | iry) |
| Ö | ath: T: Aft | tlo | 1 ☑Naturaf 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | fnjury | | k? Yes 2 □ No | | | |
| Division of | al or Atte s after des ii Directo ed in by th | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury · At hos building, etc. (Specify | me, farm, stre | et, factory, office | | 28f. Location (Street City or Town, Sta | and Number or Ru ite) | ral Route Number, |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical (| 29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination) | sician: To the best of my knowner: On the basis of examination and manner stated. | vledge, death ion and/or inv | occurred at the tin estigation, in my o | ne, date and place, pinion, death occurr | and due to the cause red at the time, date a | (s) and manner as nd place, and due | stated. to the cause(s) |
|) | To t To t | Σ | 29b. Signature and title of certifier | mn | | 29c. Licens | 127569 | 29d. [| Date signed (Month | |
| _ | | | 30. Name and address of person which | mpleted cause of death (ftem | 23a) (Typa, | 38 Gru | ene tres | e Rd | un | |
| ** | Sta Registi | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signat | we di | estel | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death dent's Name (Eirst, Middle, Last) 2. Date of Death **Physician** Day Year 2056 PM ovember 22 /Medical 200 Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **Funeral** Birthplace (State or Foreign
 Country) 1 M 2 □ F Days Hours Director 1an D Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location or 28e-f ehow 10d. Inside City Limits other treumstic event, the Medical Exercities must be notified at Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA or items 23a 606 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yolo If Yes, Give Year or Dates: Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify: 3 Widowed Divorced "natural". 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade and Mental Hygiene. Elementary/Secondary (0-12) College \$1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental F ent: If item 27 is marked of 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21/20· 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it any Injury or o Burial 2 Cremation 3 □Re moval from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee cility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ing, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** VStemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ certificate has been s rector, page 2 should Be Completed 1 Yes 2 No 3 Probably 4-Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 - No 2 ER/Outpatient 1 🗌 Inpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. narel Diractor: A 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funarel D completely filled is 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2005353 05

DHMH 17 Rev 1/2001

State

Registrar

111

lajon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

011

Registrar's Signature

(0601

31. Date filed (Month, Day, Year)

| | | | 1 _ Stata | tate of Marylan | | | of Health | and Me | ental Hy | 200 | - I-out | 30020 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------|----------------------------------|-------------------------------|---------------------------------|------------------------------|-----------------------------|----------------------------------|----------------------------------|
| | | | Ragistrar 1. Decedent's Name (First, Middle, Last) | | Cer | illicate | UI Deal | | 2. Date of De | Reg. No. U U | 5 | 3. Time of Death |
| | Physici | | MRS. DOROTHY | HARRIS | SON | | | | Month | Day | Year | M M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give stre | et and number) | Med. | 4b. City, Tow | vn, or Locatio | | doveral | 4c. County | 2005 of Death | 0 197 |
| | | | Johns Hopkins | Bayview | | Balt | imore | Mari | yland | | | |
| · · · | Funeral Director | | 5. Social Security Number 6. Sex | 7. Age (In yrs. | | If Under 1 Y | | er 24 Hrs. 8 | B. Date of Birt | | 9. Birth Cou Mary | place (State or Foreign ntry) |
| | /land | | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town or Loc | cation | | | | | | 10d. Inside City Limits |
| | n 72 hours after death with the Maryland "netural", or Itema 23a or 28a-f show saftal Exprime mai be ricitiled at | ctor | MD Baltimore | | Dunda | ılk | | | | | | 1 ☐ Yes 2 🛣 No |
| | or 28 | Funeral Director | 10e. Street and Number | | | 10f. Zip Co | de | | | 10g. Citizen of | What Cou | ntry? |
| | ath w | rai | 6719 Brentwood Aven | | | | 222 | | | USA | | |
| | ltem ltem | nue | | Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 [XNo | .S. 13. V | Vas Decedent Yes, specify | of Hispanic (Cuban, Mexic | Origin? (Speci an, Puerto Ri | ify Yes or No- can, etc.) | 14. Rad Bla | e - Ameri ck, White, | can Indian, etc. |
| 336 | urs af | by | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 1 | ☐ Yes 2【X | No Specia | ty: | | Specif | w.Whi | te |
| 9 | 72 hou | ted | 15. Decedent's Educati | | 16a. Deced | ent's Usual O | ccupation | | | 16b. Kind of B | | |
| 21 | within 7 ene. than "r | Completed | (Specify only highest grade co | College (1-4or 5+) | life. E | kind of work di OO NOT use re | lone during m etired) | ost of working | " | | | |
| 7 | be filed within tal Hygiene. Id other than event, the Ma | | 6 Years | | Hous | sewife | | | | Own Ho | | |
| and | | Be | 17. Father's Name (First, Middle, Last) | | | | | | | Maiden Suman | ne) | |
| Ž | d 2 should th and Men 7 is marke treumatic | 2 | Louis Rauf 19a. Informant's Name/Relationship (Type, | Print) | 10h Mailin | a Address /St | | Rose M | | | 0 | 0.41 |
| Maryland 21215-0036 | 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | George Harrison | Husband | | | | | | r, City or Town, k, MD。2 | | Code) |
| | f Healt frem 2 other | | 20a. Method of Disposition | 20b. P | lace of Dispos | sition (Name o | of | Novem | | 20c. Location | | own, State |
| Baltimore, | 0 0 | | 1 XBurial 2 ☐ Cremation 3 ☐ Remi 4 ☐ Donation 5 ☐ Other (Specify) | | emetery crem rist Lu | | | 28, 2 | | Dundalk | . MD | |
| alti | arta art | | 21. Signature of Funeral Service Licensee | 9 | 0 0 22 | Name and A | ddress of Fac | | | | | |
| <u> </u> | Dep du A | | Conthony C | . Conne | lly ? | 7110 So | llers | Point | Road, | Dundalk Dundalk | , MD. | 21222 |
| | | | 23a. Part1. Enter the disease, of complicati shock, or heart failure. List only one c | ons that caused the death ause on each line. | n. Do not ente | er the mode of | dying, such a | as cardiac or i | espiratory ar | rest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | Septic | Shoc | k. | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequence | uence of): | | | | | | | |
| | | e. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequ | uence of): | y Car | ncer | | | | | |
| | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | , | | | | | | | |
| o, | be executed icien and burial-transit | Exa | resulting in death) Last | Due to (or as a consequ | uence of): | | | | | | | |
| 8760, | y s | icai | d | | | | | | | | | |
| 9 | The law requires that the death certifica site has been signed by the ettending ph page 2 should be detached for use as th | Physician/Med | IF FEMALE: | | | | | | | | | |
| Вох | attend strend for us | ian/ | 23b. Was decedent pregnant in the past 12 months? | If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal | Ideath 3 🗌 | Ectopic pregn | | | | | te of deliv Inth | ery Day Year |
| P.O. | that the de ed by the detached | ysic | 1 Yes 20HM | 4□Pregnant at time of de 9□ Unknown | eath 5∐ | Other (specif) | y) | | | | | 34) |
| | res that the signed by be detacted | | Part II. Other significant conditions contrib | uting to death but not rest | ulting in the un | derlying cause | e given in Par | t I. | 23e. Did to | bacco use cont | ribute to t | he cause of death? |
| Records, | quires in sign | ed by | Renal Jeilure | Atrial | bibri | Matic | n | | 120 | es 2 🗆 No | 3 Prot | ably 4 Unknown |
| တ္ထ | law requir as been si 2 should | piet | Gout | / | , , | | | | 24a. Was | an 24b. | Were auto | psy findings available |
| | | Completed | | | | | | | autop perfor | med? | prior to co death? 1 □ Yes | mpletion of cause of 2 No |
| Division of Vital | Attending Physicien: 1 r death. sctor: After this certifical by the funeral director, p | Be | 25. Was case referred to medical examiner? | | | | 26. Pla | ice of Death (| | 1- | | 2.50140 |
| <u></u> | | ဥ | 1 ☐ Yes 2 No Hosp | 1 Minpatient 2 | ER/Outpatient | 3□ DOA | Other: 4 🗆 I | Nursing Home | 5 Resid | ence 6 🗆 Oth | er (Specii | v) |
| UC C | Jing F | ion | 1 Natural 5 ☐ Pending | 8a. Date of Injury (Month, Day Year) | 28b. Time of Injury | | Injury at Work? | | d. Describe h | ow injury occur | red | |
| isi | after death. Director: A | lical | 2 Accident investigation 3 Suicide 6 Could not be | 8e. Place of Injury - At ho | ome farm stre | | 1 Tes 2 | | f Location (S | treet and Numb | or or Pur | al Route Number, |
| Š | - 9 | Certification; | 4 Homicide determined | building, etc. (Specify | /) | et, lactory, on | nce | 20 | City or Tow | n, State) | er or mura | ar Houte Number, |
| | To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di | edicai C | (Check only 2 Medical Examiner: | an: To the best of my kno | wledge, death | occurred at the | ne time, date : | and place, and | d due to the d | ause(s) and ma | inner as s | tated. |
| | thin 2 the 1 mplet | Medi | one) 29b. Signature and title of certifier | and manner stated. | | | | | | | | |
|) | 7.8 T 8 | - | Daniel I M | 1401 - 1 - 1 | M - | | | -> P19 | | 29d. Date signe | | |
| 7 | CK. | | 30 Name and addition of | unicoa 1 | | ode 03 | 2445 | 8 | | vovem | SEL | 23,2005 |
| | 8. | | 30. Name and address of person who compi | oted cause of death (Item | | Print) 9882 | | | | | | |
| * | Sta | | 31. Date filed (Month, Day, Year) | 32. egistrar's Signa | | F + 14 | | | | | | |
| 25 | Registr | ar | NOV 2 8 2005 | Alleger) | F SO | 242) | | | | | | |

| | | | 1- State of Maryland / Der State of Maryland / Der Phy G849 11- | epartment of Health and I -28-05 tas Certificate of Death | Mental Hygieกู้ Reg. N | 005 38021 |
|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------|
| 36 | Dhuaisic | | 1. Decedent's Name (First, Middle, Last) Carmen Alicia Ha | avre | 2. Date of Death Month D | 3. Time of Death |
| *** | Physicia /Medic | | ALICE | HAVRE | | 250 20 2003 01=48 M |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Deat | | AAR FOND |
| | Funeval | # | 5. Social Security Number 6. Sex V 7. Age (In yrs. last birth | nday) If Under 1 Year If Under 24 Hrs. | | |
| | Funeral Director | | 5. Social Security Number 214-80-0054 1 M 2 D F 87 | rs. Months Days Hours Min. | July 10, 1 | 918 Puerto Rico |
| | pu , | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | or Location | | 10d. Inside City Limits |
| | haryla I shov | ٥ | Maryland Baltimore Co. | Parkville | | 1 □Yes 2X No |
| | the N | Directo | 10e. Street and Number | 10f. Zip Code | 10g. C | itizen of What Country? |
| | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Items 23s or 28s-f show armatic event, the Madical Exam. or must be notified at | | 7005 01d Harford Road | 21234 | l | Inited States |
| | deat | Funerai | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer | pecify Yes or No- to Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 36 | or it | by Fu | 1 □ Never Married 2 【 Married 1 □ Yes 2 【 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: | 1 X Yes 2 No Specify: Pue | | Specify: White |
| 5-0036 | hours tural | | | Decedent's Usual Occupation | 16b. | Kind of Business/Industry |
| 75 | nin 72 in "na Matik | piet | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give kind of work done during most of wo life. DO NOT use retired) | rking | |
| 212 | d with | Completed | 12 yrs. | Homemaker | | Own Home |
| nd | 9 7 5 | Be | 17. Father's Name (First, Middle, Last) | | me (First, Middle, Maide | |
| Z | should and Men marke umatic | ٩ | Luis Velez | Mailing Address (Street and Number or Ri | | or Town State Zin Code) |
| Maryland 2121 | es 1 and 2 should b of Health and Ment f Item 27 is marked ir other traumatic | | 19a. Informant's Name/Relationship (Type, Print) Mrs. Shirley Cartier / Daughter | 28 Huntington Place | _ | |
| | Heal Heal tem 2 | | 20a. Method of Disposition 20b. Place of | Disposition (Name of | Date 20c. I | Location - City or Town, State |
| Baltimore, | Pages nent of I ant: If Its ary or o | | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Entompment Dulaney | Valley Mem. Gardens 11/ | 23/2005 Tin | nonium, Maryland |
| a E | permit. Page Department Important: I any injury o | | 21. Signature of Funeral Service Licensee Michael E. Canapp | 22. Name and Address of Facility | 5305 | Harford Road |
| <u> </u> | 88 5 8 | | W. C. C. C. | Leonard J. Ruck, | Inc. Balt | imore, MD 21214 |
| | | | 23a. Part1. Enter the disease, or €omplications that caused the death. Do n shock, or heart failure. List only one cause on each line. | ot enter the mode of dying, such as cardia | c or respiratory arrest, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | HEMATOMA | | |
| | /Medical Examiner | | Due to (or as a consequence of | | 2 | |
| | 10 P. P. S. | er | Sequentially list conditions, if any, leading to immediate | HEAD TRAUM | И | |
| 16 | cuted id ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | |
| 0 | ate be executed hysicien and the burial-transit | Ex | resulting in death) Last Due to (or as a consequence of | if): | | |
| 8760, | cate be executed physicien and the burial-transit | dicai | d | | | - |
| 9 X | The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as in | Physician/Me | IF FEMALE: 23c. If yes, outcome of pregnancy | THE RESIDENCE OF THE PARTY OF T | | 23d. Date of delivery |
| Box | atten afor u | clan | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 1☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | Month Day Year |
| P. 0. | that the de ad by the detached | hysl | 9 ☐ Unknown | | | |
| | res tha igned I be det | by P | Part II. Other significant conditions contributing to death but not resulting in | the underlying cause given in Part I. | | use contribute to the cause of death? |
| ord | w require been si should t | | | | 1 🗌 Yes | 2 Probably 4 □Unknown |
| ec | e taw r has be | Completed | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of |
| E | | | | | 1 ☐ Yes 2 Ø N | death? 1 Yes 2 No |
| <u> </u> | sicien: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? Hospital: | Othor | ath Check only one) | 4 Tou (2) |
| Division of Vital Records, | Physic this stal di | ı; To | 27. Manner of Death 28a. Date of Injury 28b. T | ime of 28c. Injury at | dome 5 Residence 28d. Describe how inj | ury occurred Ty, co |
| <u>o</u> | nding ath. r: Afte e fune | Certification; | | njury Work? | envolte h | s beducem from |
| Vis | r Attendi er death. rector: A by the fu | tifle | 3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify) | m, street, factory, office | 28f. Location (Street a City or Town, Sta | and Number or Rural Route Number, |
| ۵ | ital or A irs after rel Direc led in by | | Home - Bor | 166M | 28 4027129 | TOPPL BERMY SICIL |
| | • Hospital 24 hours a • Funerel letely filled | edical | 29a. Certifier 1☐ Certifying Physician: To the best of my knowledge (Check only 2☐ Medical Examiner: On the basis of examination and | | | |
| | To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. | Med | one) and manner stated. 29b. Signature and title of certifier | 29c. License number | 29d. C | ate signed (Month, Day, Year) |
| | F 3 F 8 | | Manual Ahm m | . D. D 21809 | ~10 | Jems en 21, 2005 |
| | 1 D | | 30. Name and address of person who completed cause of death (Item 23a) (| | | 5 .5 |
| | | | | K NO T. MONION | MD 21 | 7 93 |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Sta | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | Soule | | |
| | Registi | aı | NOV 2 8 2005 Person A. A. | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 22, 2005 **Physician** Eleanor Mary Harvey 1:10 a. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville Baltimore Co. Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 25, 1 Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 X F Months Days Hours Min 081-16-1444 87 Yrs. New York Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Parkville Directo Maryland Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21234 8800 Walther Blvd. United States Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 □ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Mental I Loretta Brady Denis Μ. Morrissey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, D.C. 20007 4565 MacArthur Blvd. N.W. Mrs. Denise H. Liebowitz / Daughter If of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ō Department of Important: If any injury or once. Dec. 14,2005 Arlington, VA Arlington National * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementin disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ of Vital Records, 3 Probably 4 Dunknown 1 Yes - Z No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☐ No 24a. Was an 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4. Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Hospital or Attanding 1 Hatural 22 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkalle mo ef-FFEO Kindrom Walth 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2005 Registrar

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Harvey,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amena Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene () () 5 1 - For Stata Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Yea **Physician** 5:20 NOU 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itema 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funerai Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: 3 Widowed 4 □ Divorced Completed by "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than " College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: if Item 27 is any injury or other trat ance. 20a. Method of Disposition

Burial 2 Cremation Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) eavera 21. Signature of Funeral Service Licensee vias ORKHOOD 212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyob, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Condinac Louin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 Yes 2 No 4 ☐Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Many er of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury To the Hospital community within 24 hours effer death.
To the Funeral Director: After completely filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1© Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Maney

Registrar DHMH 17 Rev 1/2001

State

Memorial

Union

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Makanen

Nathani

31. Date filed (Month, Day, Year)

within 24 hours af To the Funeral D completely filled in Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a place.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

enuca

29c. License number 29d. Date signed (Month, Day, Year) OCME

NOVEMBER 20, 2005

Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201 107

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 05 38026 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) AKA: Carol Joanne Cronin Hammer 2 Date of Death 3. Time of Death **Physician** Year 8:10 PM M Cronin Hammer 19. Nov. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3010 Courtside Road Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Yrs Director 013-30-6549 67 Nov 11, 1938 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
It is marked other then "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinant must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Prince George's Mitchellville 10e, Street and Number 10g. Citizen of What Country? 3010 Courtside Rd. 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Homemaker/Human Resources Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Cronin Florence Mahoney ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 s ment of Health an item 27 other tra Mara Hammer-McBee (Daughter) 10344 Augusta Ln. Piqua, OH 45356 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
ony injury or o Forest Hill Cemetery 11-26-05 Piqua, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Jamieson & Yannucci Funeral Home do 333 W. High Street Piqua, OH 45356 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratic Cardrovescular Heart Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Social field is conditional if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) nding physicien and use as the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached Ö 9□ Unknown 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. The law requires 1 Yes 2 No 3 Probably 4 nknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physician: After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funerel Director: / completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO055927 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drivey Cleverly, Mary LAND 3001 Hospital Sylvate, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2005 Registrar

| | | | 1 - For State Registrar | Sta | ate of M | arylar | | artmen rtificat | | | and M | iental Hy | giene Reg. No | 2001 | 5 | 3802 | 7 |
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| | Physic | ian | Decedent's Name (First, Middle | | 11 | | | | | | | 2. Date of De | | / Ye | ar | 3. Time of De | |
| | /Medi | cal | Gerhard | | Hui | | | | | | | NOV | 2 5 | | 05 | 5:00 | PM |
| | Exami | ner | 4a. Facility Name (If not institution | | | | - | | Town, or Colum | Location o | of Death | | 4c. | County of [| | , | |
| | Funeral | _ | Howard County 5. Social Security Number | Gener 6. Sex | | | last birthday) | If Under | 1 Year | If Under | 24 Hrs. | 8. Date of Bir | th | | Ward | | |
| | Director | | 558-56-7093 | 1 X M 2 | | 75 | Yrs. | Months | Days | Hours | Min. | 8. Date of Bir (Month, Date 2/22/1 | iy, Year) .930 | 9. Birthplace (State or Foreign Country) Germany | | | ireign |
| | pu , | | Usual Residence of Decedent 10a. State 10b. County | | | 10- 03 | y, Town or Lo | | | | | | | | | | |
| | ours after death with the Marylan rel', or Items 23a or 28e-1 show Examilied at | 5 | Md. How | bre | | TOC. CIL | • | | | | | | | | 10 | d. Inside City L 1 ☐ Yes 2 € | |
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| | death ms 2 | Jera | 11. Marital Status | 12. W | as Decedent | Ever in U | .S. 13. \ | Was Deced | | | | ecify Yes or No Rican, etc.) |)- | 14. Race - A | | n Indian, | |
| 9 | after or Ite | Ē | 1 ☐ Never Married 2 ☐ Marr | ed 1 (| med Forces? □Yes 2√∑ Yes, Give | No | | _ | | | , Puerto | Rican, etc.) | | Black, V | | | |
| 8 | "naturel", or | d by | 3 ☐ Widowed 4 🙀 Divorced | Ye | ear or Dates: | | | 1□Yes 2 | | Specify: | | | | Specify: V | √hit | e | |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland tal Hyglene. d other than "naturel", or tems 23a or 28e-f show event, tre Modical Exercited to the trial be recitled at | Completed | 15. Deceden (Specify only highes | 's Education t grade com | pleted) | | 16a. Deced | lent's Usua kind of wor DO NOT us | k done d | urina mosi | of worki | ng | 16b. Ki | nd of Busine | ss/Indu | stry | |
| 112 | filed withir Hygiene. ther than int, it e M. | dwo | Elementary/Secondary (0-12) | Co | ollege (1-4or | 5+) | | ospac | , | | c+ | | 1 | Aerosp | ace | | |
| þ | illed Hygid other | BeC | 17. Father's Name (First, Middle, | Last) | | | | - Li dio | | | | (First, Middle, | Maiden | Sumame) | | | |
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| an | 2 sho and I is me | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru | | | | | | | | | r or Rura | Il Route Numbe | er, City o | Town, Stat | e, <i>Zip</i> C | iode) | |
| | 12 # Z | 1 8 | Thomas Huwe/so | on | | 1 | 8049 | Red . | Jack | et Wa | у Је | ssup.M | 1. 20 | 794 | | | |
| Baltimore, | m 0 . | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | 3 □Remov | al from State | 0 | lace of Dispo emetery, cren | sition (Nam natory or ot | ne of ther place |) | D | ate | 20c. Lo | cation - City | or Tow | n, State | |
| Iţim | it. Pa rtmen rtent: njury | 11/26 | | | | | | | | | 1/26 | /2005 | Ca | ille | e,Md. | | |
| Ba | Burial 2 Ucremation 3 Removal from State Metro Crematory 11 | | | | | | | | | Ta P | rke er | licot | | | F.H.Ind. 2104 | | |
| | Fri ysicia n /Medical | | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | a | se on each II | e bra | l Hen | norsh | | , such as | cardiac o | r respiratory ar | rrest, | | l d | Approximate interval Between Disert and Deat Scill S | |
| E | Examiner | | Cognostially list conditions | b. — | | | , | | | | | | | | | | |
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| V | be executed ician and burial-transit | Examiner | that initiated events resulting in death) Last | c | Due to (or as | 0.0000000 | vanes of): | | | | | | | | | | |
| 8760, | cate be ex thysician the buria | | | | 5 de 10 (51 d3 | a conseq. | 261106 01). | | | | | | | | | | |
| 687 | ficate phys sphys | edical | | d | | | | | | | | | | | + | | |
| Box | requires that the death certificate een signed by the attending phys hould be detached for use as the | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 4 5 | ves, outcome Live birth Pregnant at Unknown | 2 Fetal | death 3 🗌 | Ectopic pre Other (spe | | | | | 2 | 3d. Date of Month | delivery D | ay Year | |
| , P.O | es that the igned by be detact | | Part II. Other significant condition | ns contributi | ng to death b | ut not resu | ulting in the un | derlying ca | use giver | n in Part I. | | 23e. Did to | bacco u | se contribute | to the | cause of death | ? |
| Vital Records, | w requires been sign should be | ed by | Hupe tensic | 2 | | | | | | | | 1 🗆 Y | 'es 2[|]No 3□ | Probab | ly 4 ☑Unkn | own |
| 900 | aw re | Completed | 1 * | | | | | | | | | 24a. Was | | 24b. Were | autops | y findings avail | able |
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| /ita | ysiclen: Th is certificate director, pag | Be (| 25. Was case referred to medical examiner? | Į. | | | | | | 26. Place | of Death | Check onl or | | | | | -17 |
| | ys dis | 2 | 1 ☐ Yes 2 ☑ No | Hospita | 1 Inpatie | | ER/Outpatient | | 475 | 4 LI NUI | | ne 5□ Resid | | | oecify) | | |
| nc | 0 0 | lon | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | | . Date of Inju (Month, Da | y Year) | 28b. Time of Injury | | Bc. Injury a Work? | · | | 8d. Describe h | ow injury | occurred | | | |
| Division of | Attending r death. sector: After by the funer | Certification; | 2 Accident investig 3 Suicide 6 Could n | ot he | . Place of Ini | Jrv - At ho | me farm stre | M et factory | | es 2□N | - | 8f. Location (S | treet ann | Numberor | Dural D | louto Number | |
| <u>S</u> | after after Dire | erti | 4 Homicide determi | 180 200 | building, et | . (Specily | me, farm, stre | et, ractory, | Office | | | City or Tow | n, State) | rvamber or | nurai n | oute variber, | |
| | To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral | | 29a. Certifier 1 Certifying | Physician: | To the best | of my knov | viedge, death | occurred a | t the time | , date and | place, a | nd due to the o | ause(s) | and manner | as state | ed. | |
| | he Hin 24 in 24 he Fu | edical | (Check only 2 Medical E | xamıner: 🔾 | n the basis of id manner sta | examinat | ion and/or invi | estigation, i | in my opii | nion, death | occurre | d at the time, o | date and | olace, and d | ue to th | e cause(s) | |
| | with To 1 | Σ | 29b. Signature and title of certifier | | 14.0 | | | _ | License | | | | | signed (Mo | | | - |
| | | | Men 4 | uc. | M.D. | | | |) 00 | 636 | 53 | | No | ember | 25 | ,2005 | |
| _ | <i>j</i> 0 | | | no complete | ed cause of d | eath (Item | 23a) (Type, F | Print) | ane | Co | lumb | ia, Mar | yland | 210 | 44 | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 2005 | 32. Registra | ar's Signat | | de la companya dela companya dela companya dela companya de la companya de la companya de la companya dela companya de la companya de la companya de la companya dela compan | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 21 LLEN HAWKS 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Avenue Towson 1506 LaBelle If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, October 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☑ F 84 Yrs. 427-22-3631 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No MD Baltimore Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1506 LaBelle Avenue 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 Yes 2 No þ 3 Widowed 4 Divorced

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.
Important: If itam 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examinating Italianal anges. Maryland 21215-0036 Baltimore,

Completed

To Be (

15. Decedent's Education (Specify only highest grade completed)

30. Name and address of person who completed cause of death (Item 23a) (T

2005

BRUCE 31. Date filed (Month, Day, Year)

Elementary/Secondary (0-12)

College (1-4or 5+)

a

Ellen

Physician /Medical Examiner

> Examine ted by the attending physicien and detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical has

within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

| Elementary/Secondary (0-12) | College (1-40r 5+ |) | Reporter | | | Sun Paper | • |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|------------------------------------------|----------------------------------------------|
| 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | ame (First, Middle, M | aiden Sumame) | |
| John Wright | McCrac | ken | | Lucy | | Baxter | |
| 19a. Informant's Name/Relationship (Ty) | oe, Print) | 19b. | Mailing Address (Str | eet and Number or F | Rural Route Number, | City or Town, State | , Zip Code) |
| Marshall W. Hawks- | -son | 15 | 900 York | Rd., Spark | ks, MD 21 | 152 | |
| 20a. Method of Disposition 1 □ Burial 2 □XCremation 3 □ R 4 □ Donation 5 □ Other (Specify) | emoval from State | cemetery | Disposition (Name of crematory or other processing partice) | place) | Date 2 /23/05 | Oc. Location - City o | |
| 21. Signature of Funeral Service License | ⇔ William | G. Dau | I VANCOUR HOLD CONTROL OF | ddress of Facility Ruk Rd., Tou | CONTRACTOR OF THE PARTY OF | Funeral 21204 | Home, Inc. |
| 23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | buy consequence | oculial n. | | - | st, | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown | 3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown | Fetal death | 3 □Ectopic pregna 5 □ Other (specify | | | 23d. Date of d | delivery Day Year |
| Part II. Other significant conditions con | etributing to death but | not resulting in | the underlying cause | given in Part I. | 23e. Did tob | | lo the cause of death? Probably 4 □Unknow |
| | | | | | 24a. Was an autopsy perform 1 Yes 2 | prior t | |
| 25. Was case referred to medical examiner? | loopital: | | | | eath Check only one | | |
| 1 163 22 140 | ospital: 1 Inpatient | | | | Home sider | | pecify) |
| 27. Manne of Death 1 | 28a. Date of Injury (Month, Day | Year) 28b. Ti | jury | njury at Work? 1 ∐ Yes 2 ∐ No | 28d. Describe how | w injury occurred | |
| 3 Suicide 6 Could not be determined | 28e. Place of Injur building, etc. | y - At home, far (Specify) | m, street, factory, off | IC8 | 28f. Location (Str. City or Town, | eet and Number or State) | Rural Route Number, |
| 29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin | sicien: To the best of ner: On the basis of e | xamination and | death occurred at the for investigation, in r | ne time, date and place my opinion, death occ | ce, and due to the ca curred at the time, da | use(s) and manner te and place, and d | as stated. ue to the cause(s) |
| 29b. Signature and title of certifier | Jane | · lio | // | cense number | | d. Date signed (Mo | |

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

DHMH 17 Rev 1/2001

State Registrar

32 Registrar's Signature

| | | | 1 - For State Registrar | State of Maryland | d / Depa | | Health and | Mental Hyg | iene | 5 38029 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------|--------------------|-------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------|
| | Physic /Medi Exami | cal | Decedent's Name (First, Middle, Last) Sister Alice M. 4a. Facility Name (If not institution, give: | . Halpin, SNDd | eΝ | 4b. City, Town, | or Location of Dea | 2. Date of Deat Month NOVEMBE | Day Y | 3. Time of Death M Death |
| * 1 | Funeral Director | 8, F. | Saint Joseph 5. Social Security Number 6. Sev | | iter Ist birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hr | | Year) 1921 | Baltimore B. Birthplace (State or Foreign Country) Pernsylvania |
| | פ | tor | Usual Residence of Decedent 10a. State 10b. County MD Balti | 10c. City, | Town or Lo | cation | | November | | 10d. Inside City Limits 1 Yes 2 XNo |
| | ath with the | Funeral Director | 10e. Street and Number 1531 Greenspring | y Valley Rd. | | 10f. Zip Code 2115 | 3 | 10 | Og. Citizen of Wh | • |
| 980 | n 72 hours after death with the Maryland "netural", or items 23a or 28a-f show adjoal Exartil at must be notified at | b | 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 | Was Decedent of If Yes, specify Cub | | Specify Yes or No- rto Rican, etc.) | | American Indian, White, etc. White |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hyglene. Important: if item 27 is marked other then "netural", or it any folyary or other traumatic event, its Mudical Expris. Once. | Completed | 15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12) | cation e completed) College (1-4or 5+) | (Give life. L | dent's Usual Occup kind of work done DO NOT use retire | during most of w | orking 1 | 6b. Kind of Busin | |
| yland? | nould be filed if Mental Hyg narked othe | To Be C | 17. Father's Name (First, Middle, Last) Harry | Halpin | | | Ali | | Hic | ggins |
| ore, Mai | ss 1 and 2 st of Health and item 27 is n other traun | | 19a. Informant's Name/Relationship (Ty). Sisters of Notre Dame (20a. MeRod of Disposition | de Namur 20b. Pla | 1531 ice of Dispo | | oring Val | Rural Route Number, Lley Rd., Date 2 | Stevens | |
| Baltimore, | permit. Page Department Important: if any injury o | 1 8 | 1 | Ilch | nester au 22 | Cemeter . Name and Addre | y 11 | /29/05 luck Towso | n Funera | t City, MD al Home, Inc. |
| | Physician /Medical Examiner | Iner | 23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequential / list conditions of any, leading to immediate cause. Enter Underlying | cations that caused the death. e cause on each line. CEREBRAL Due to (or as a conseque CDAGULDFA Due to (or as a conseque | Do not ente | er the mode of dyi | | wson, MD ac or respiratory arre | 21 204 st, | Approximate Interval Between Onset and Death |
| x 68760, | ertificate be executed ding physician and se as the buriat-transit | /Medical Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseque | nce of): E HEA | AT-ON | .UR | | | |
| P.O. Box | The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th | Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown | léath 3 🗌 | Ectopic pregnancy Other (specify) | / | | 23d. Date o Month | f delivery Day Year |
| ords, F | w requires that been signed should be de | by | Part II. Other significant conditions con | tributing to death but not result | ing in the un | derlying cause giv | en in Part I. | 23e. Did toba | | te to the cause of death? Probably 4 \ Unknown |
| Vital Records, | an: The law lificate has b or, page 2 st | e Completed | 25. Was case referred to medical | ÷4. | | | | 24a. Was an autopsy perform | prio dea No 1□ | e autopsy findings available r to completion of cause of th? Yes 2 No |
| | Physician: r this certifica ral director, I | ToB | examiner? | ospital: | R/Outpatient | 3□ DOA Oth | | ath <i>(Check only one)</i> Home 5 ☐ Residen | | Speciful |
| Division of | tending leath. tor: Afte the fune | Certification: 7 | 27. Manner of Death 1 GNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | 28a. Date of Injury (Month, Day Year) | 8b. Time of Injury | 28c. Injur Wor M 1 [| | 28d. Describe how | injury occurred | |
| .≥ Oi | | al Certif | 4 Homicide determined 29a. Certifier 15 Certifying Physic | 28e. Place of Injury - At hom building, etc. (Specify) | edge, death | occurred at the tin | ne date and plac | City or Town, | State) | or Rural Route Number, |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | Medical | 29b. Signature and title of certifier | and manner stated. | n and/or inv | estigation, in my o | pinion, death occ | urred at the time, dat | e and place, and d. Date signed (A | due to the cause(s) |
| ho | | | 30. Name and address of person who cor | mella m.c | | | 1412 | 54 | wemper & | えり つって |
| 3 | Sta Registr | _ | 31. Date filed (Month, Day, Year) | 32. Registrar's Signatur | 6-21-1 (| DSLER D | RIVE, | FOWSON, I | MARYLAN | ID 21204 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Samuel William Hasson. Jr. November 2005 2:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 26, 1924 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**√** M 2□ F 219-16-3929 81 Maryland Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examinar must be notified at MD Baltimore Parkville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 8364 Ridgely Oak Road Items 23a 21234 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No WW II If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ٥ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Edgewood Arsenal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel William Hasson, Sr. Anne Loretta Rosenberger ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra once. Adalee R. Hasson-wife 8364 Ridgely Oak Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 11/26/05 Baltimore. MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No 1 ☐ Yes or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Certification: To 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 143725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Year)
NOV 2 8 2005



Marke)

| | | | 1 - For State Registrar | State of M | Maryland / De | partmer ertificat | | | | Re | g. No. U | 05 | 38031 |
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| | Physici | | Decedent's Name (First, Middle, Last) FRANK SHRIVE | | | | | | | ate of Death lonth Ember 2 | 26, Da 2005 | Year | 3. Time of Death 10:19P M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give s Union Memorial Hospital | street and numbe | er) | 4b. City | Town, or Balti | Location of | of Death | | 4c. County | | |
| | Funeral Director | | | | Age (In yrs. last birthd 91 Yrs | Months | Days | If Under a | | ate of Birth fonth Day 311Der 2 | 24,1914 | 9. Birth | place (State or Foreign Tand |
| | e Maryland a-f show | ctor | Usual Residence of Decedent | | 10c. City, Town o | | | | | | | | 10d. Inside City Limits |
| | h with th | al Dire | 10e. Street and Number 10 Overhill Road | | | | 21210 | | | 10 | og. Citizen of V USA | What Cou | ntry? |
| 036 | be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "neturel", or fleme 23s or 28s-f show event, fire Madical Exarts derminate notified at | by Funeral Director | 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced | 12. Was Decede Armed Force 1 XX es 2 [If Yes, Give Year or Date | □No MMII | 3. Was Dece If Yes, spe | | spanic Orig n, Mexican Specify: | gin? (Specity Y , Puerto Rican | es or No- , etc.) | | ck, White, | can Indian, etc. ite |
| Maryland 21215-0036 | ed within 72 ho giene. or then "netu | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | | (G | cedent's Usu ive kind of wo e. DO NOT u Stock E | ork done d ise retired | during most) | t of working | | 16b. Kind of Bu | usiness/In estme | |
| land | ild be filed lental Hygi- ked other ic event, I | 9 | 17. Father's Name (First, Middle, Last) John Marshall Jones | | | | | | r's Name <i>(Fir</i> s annette (| | | 10) | |
| Mary | d 2 shouth and N 7 is maintained | - | 19a. Informant's Name/Relationship (Ty, | ре, Print) | Wife 10 0 | ailing Address | s (Street a | and Numbe Baltim | or or Rural Rou | te Number, yland 2 | City or Town, | State, Zip | Code) |
| ď. | permit. Pages 1 and Department of Healt Important: if item 2 any injury or other once. | | 20a. Method of Disposition XX Burial 2 □ Cremation 3 □ R Donation 5 □ Other (Specify) | emoval from Sta | 20b. Place of Di cemetery, Druid Rid | crematory or a | other plac | | Date 11/30/05 | | oc. Location - | - | |
| Balt | permit. Departr Importe any inju | | 2 Ignature of Funeral Service License MMS August 2 Ignature of Funeral Service License | Rua | ps | | | 650 | 0 York Ro | oad Bal | timore, | | Home Inc and 21212 |
| | Physician // Medical Examiner and prize personal fitte prize fitte prize fitte prize fitte prize fitte prize fitte | Ical Examiner | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or Due to (or Due to (or Con | ed the death. Do not n line. Cardial as a consequence of): Gestive as a consequence of): Onic Obs as a consequence of): ertensio | Infar Heart truct | ctio Fai | n lure | | | | | Approximate Interval Between Onset and Death |
| .O. Box 687 | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | | 2 Fetal death at time of death | 3 □Ectopic p 5 □ Other (s _j | | | | | 23d. Dat | te of delive | ery Day Year |
| ۵. | w requires that the back of th | by | Part II. Other significant conditions cor | ntributing to death | n but not resulting in th | e underlying (| cause give | en in Part I. | 2 | | acco use conti | | he cause of death? |
| of Vital Records, | The ate h page | Completed | ge Wa | | | | | | 1 | | ned? | prior to co death? | opsy findings available mpletion of cause of 2 No |
| of Viit | Physician: this certific ral director, | To Be | I Les ALMINO | lospital: 1 🔲 Inpa | | | | er: 4 □ Nu | of Death (Che rsing Home | | | er (Specif | ý) |
| Division o | Attending r death. octor: After by the fune | Certification: | 27. Manner of Death 1 | 28a. Date of li (Month, i | njury Day Year) Injury - At home, farm etc. (Specify) | M M | | rat t? Yes 2 □ t | No 28f. L | | | | al Route Number, |
| ۵ | Hospita 4 hours Funeral ely filled | edical Cer | (Check only 2 Medical Examil | sician: To the be | st of my knowledge, d | eath occurred | at the tim | e, date an | d place, and di | ue to the ca | use(s) and ma | nner as s | tated. |
|) | To the Hos within 24 h To the Fun completely | Med | 29b. Signature and title of certifier Refreeal R | hinton | . M. | | c. License | 6136 | 9 | | Novem | | Day, Year) 26, 2005 |
| 1 | ۲" | | | son, M | D Union | | ial | Hosp | ital | | | | |
| | Sta Registi | | 31. Date filed (<i>Month, Day, Year</i>) NOV 2 8 200 | A | strar's Signature | rache s | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Ragistra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last Year **Physician** November 21 2005 /Medical acility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrd. last birthday) Memoria Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Days Min Year -048 20-50-0485 Usual Residence of Decedent Director so with death with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, the Medical Exandral must be notified at 1 PYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 d Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Internation 27 is marked other than "natural", or ites Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementan/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition

Burial 2 Cremation Place of Disposition (Name of 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses lun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Bladder seven months disease or condition resulting in death) Cencer /Medical Due to (or as a consequence of): Examiner HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) cele has been signed by the a page 2 should be detached by 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No performed 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funaral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) * Kouertehou! AT2438946 November 24 200 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Jocely ne KOLUTTCHOU

31. Date filed (Month, Day, Year)

ORIGINIAL

Union

32. Registrar's Signature

Memorial Hospital, Mel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie [2] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month JeFFerson Year Lenoble November 21 2005 515W /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2000 Samoritan Ba N 140s 8. Date of Birth Month, Day, June 7, 7. Age (In yrs. last birthday) 5. Social Security Number If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1□M 2**□**F Months Hours Min. 17 214-38-3326 Usual Residence of Decedent Director (o mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene. ortent: If item 27 is marked other than "neturel", or items 23e or 28e-f show injury or other treumatic event, it is Michical Extendited at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 1 Xes 2 No Hmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 <u>562</u> due Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tousew, FE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herman Lea ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5625 Purch Jef Fenson In /HUSby ue Avenue William T. L. Baltimone MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methød of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Memory & Pank 26 105 21. Signature of Tun ral Service Lic nsee 22. Name and Address of Facility
Havi P. Close Road, Baltmore Sewice, Hari 5126 · Close Belown mos 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 orardi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the filled in by the funeral director, page 2 should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? : After t 28b. Time of 28d. Describe how injury occurred 1 Tural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) NOV 28 2005

29b. Signature and title of certifier



MI

29c. License number

26

29d. Date signed (Month, Day, Year)

| | | | For | State of Marylan | | | | | d Mental Hy | - | | | |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------|--------------------------------------------|------------------------------------|----------------------------------|--------------------------------------------|---------------------------------|------------------------------------------------------------|--|--|
| | | | 1 - State Registrer | | Cei | tificate | of L | Death | | Reg. No.U U | 38034 | | |
| | Physici | an | Decedent's Name (First, Middle, Las | 1) | | | | | 2. Date of Do Month | Day | 3. Time of Death | | |
| | /Medic Examir | cal | Cynthia B. 4a. Facility Name (If not institution, give | Jones | | 4b. City. T | Town, or | Location of D | 11 eath | 18 20 4c. County o | | | |
| | Exami | lei | 10108 Cascade I | | | | | s Mil | | Balto. Co. | | | |
| | Funeral | | 5. Social Security Number 6. Se | 7. Age (In yrs. | | If Under | 1 Year Days | If Under 24 I | Hrs. 8. Date of Bi Min. 9–19– | | 9. Birthplace (State or Foreign Country) N. C. | | |
| | Director | | Usual Residence of Decedent | [™] X [□] F 56 | Yrs. | | | | 9-19- | 1949 | N.C. | | |
| | ryland how | | 10a. State 10b. County | 10c. Cit | y, Town or Lo | cation | | | | | 10d. Inside City Limits | | |
| | Ba-1 s | Director | MD Balto. | Co. O | wings | Mil | 1 | | | | 1 ☐ Yes 2 XNo | | |
| | a or 2 | Dire | 100. Street and Number 10108 Cascade F | מם פוניי | | 10f. Zip (| | 1 7 | | 10g. Citizen of Wh | , | | |
| | death ms 23 | Funeral | 11. Marital Status | 12. Was Decedent Ever in U. | .S. 13. V | | 2111 ent of His | | ? (Specify Yes or No uerto Rican, etc.) | U.S.A | - American Indian, | | |
| 9 | or Ite | Fur | 1 ¼ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 No If Yes, Give | | Yes, specr □ Yes 25 | | n, Mexican, Pu Specify: | uerto Rican, etc.) | | White, etc. | | |
| 215-0036 | within 72 hours after death with the Maryland nne. than "natural; or Items 23a or 28a-1 show 'na Medical Examirer must be notified at | d by | 3 Widowed 4 Divorced | Year or Dates: | | | | | | | Black | | |
| 15 | n "nat | piete | 15. Decedent's Ed (Specify only highest grad | de completed) | 16a. Deced (Give life. L | lent's Usual kind of work DO NOT use | l Occupa k done d e retired) | ation furing most of } | working | 16b. Kind of Bus | iness/industry | | |
| 212 | er tha | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) 4+ | | | | nolog | | Lab C | orp | | |
| and | be file | Be | 17. Father's Name (First, Middle, Last) | T | | | | | Name (First, Middle | | | | |
| Maryland | should nd Mer marke matic | 2 | Arthur 19a. Informant's Name/Relationship (7 | Jones | 19h Mailin | a Address / | (Street a | | otelle Rural Route Numb | | ones | | |
| Ma | nd 2 salth ar 27 ls | 3 | | (father) | | | | | | | lls MD 21117 | | |
| Baltimore, | of He | | 20a. Method of Disposition **Marial 2 Cremation 3 | 20b. P | lace of Disposemetery, cren | sition (Name | e of her place | 9) | Date | 20c. Location - C | | | |
| ij | Pag tment tent; I | l a | *4 ☐ Donation 5 ☐ Other (Specify | Arl | butus | Mem. | Pa | ırk 11 | -25-05 | Arbutus | s MD | | |
| Bal | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any hijury or other treumatic event, the Madical Experiment must be notified at any lours. | | 21. Signature of Fine Service Lice Cec 1 %. Fs | ep r 5 | left. | Name and Step 300 E | Address Bro Luta | s of Facility others aw PL | Funera Balto. | l Servio | ce P.A. | | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | lications that caused the death ne cause on each line. | n. Do Hot ente | er the mode | of dying | g, such as card | diac or respiratory a | rrest, | Approximate Interval Between Onset and Death | | |
| | Pnysician /Medical | ğ 1 | Immediate Cause (Final disease or condition resulting in death) | a Myora | | 121 | 160 | 13 23 | (00) | | Oriset and Death | | |
| | Examiner | | | Due to (or as a consequ | uence of): | riel | 17/1 | 104 | | | | | |
| | P # | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Dua to (or as a consequ | wire of). | | 1 | | | | | | |
| | be executed sician and burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequ | ser ser | -20 N | J | | | | | | |
| 8760, | ate be ex hysician a the burial | lical E | | d ==================================== | 307.00 | | | | | | | | |
| 9 | tificate ng phy as the | Medic | | u | | | | | | | | | |
| Вох | leath certific attending p | an/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregna 1□Live birth 2□Fetal | | Ectopic pre | gnancy | | | 23d. Date | | | |
| | The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Med | 1 Yes 2 No | 4□Pregnant at time of de 9□ Unknown | eath 5 | Other (spec | crfy) | | | Month | n Day Year | | |
| , P.O | res that I | by Ph | Part II. Other significent conditions ce | ntributing to death but not resu | alting in the un | derlying cau | use givei | n in Part I. | 23e. Did t | obacco use copinib | ute to the cause of death? | | |
| Vital Records, | w require been sig should b | ted t | 12 y pulpe | Lonea | | | | | _ 1 🗆 ' | Yes 2₽No 3 | Probably 4 Unknown | | |
| ecc | has be | Completed | [Misa [| 1 sicks: | | | | | 24a. Was | osy, pric | re autopsy findings available or to completion of cause of | | |
| al F | | | Dichetic | Meeron | بهلا | 1 | | | 1 ☐ Yes | | ath? I Yes 2□ No | | |
| | Physicien: this certific ral director. | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ I | ER/Outpatient | 3□ DOA | | | Death <i>Check onl</i> of | | (Specify) | | |
| | ding Phi h. After thi funeral | J: UC | 27. Manner of Double 1 | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | | c. Injury Work | at | | how injury occurred | | | |
| Division | or Attending after death. Director: After in by the funer | catio | 2 Accident investigation 3 Suicide 6 Could not be | | | М | 1 🗆 Y | es 2 No | | | | | |
| Div | of or Attend after death Director: , I in by the f | Certification: | 4 Homicide determined | 28e. Place of Injury - At ho building, etc. (Specify | me, tarm, stre | et, factory, | office | | 28f. Location (: City or Tox | Street and Number vn, State) | or Rural Route Number, | | |
| | To the Hospitel or within 24 hours at To the Funerel D completely filled in | | 29a. Certifier 1 Certifying Phy | sician: To the best of my know | wledge, death | occurred at | t the time | e, date and pla | ace, and due to the | cause(s) and mann | er as stated. | | |
| | the Honin 24 the Fu | dedicai | One) | ner: On the basis of examinat and manner stated. | ion and/or inv | | | | | | | | |
| | with Con | Σ | 29b. Signature and title of certifier | 1 | 10 | 290. | License | number | ĺ | 29d. Date signed (/ | Month, Day, Year) | | |
| 1 | 5 | 2 | 30. Name and address of person who co | ompleted cause of death (Itam | 23a) (Type F | Print) | , (| 10) | | 11/99 | KUL | | |
| L | | | Robert Ko | 20000 | CIC | (M. | Ú | | | | | | |
| | Sta | | 31. Date filed (Month, Day, Year) NOV 2 8 2 | 32. Registrar's Signat | ure Lo | 9 40 - | - | | | | | | |
| | Registr | ar | NOV 2 8 2 | Mague 1 | J. fly | real) | 71 | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 38035 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 20059-10 AM Ristern NOV 22 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 24 Hrs. 8. Date DAHIMOCS MURBING C 6. Sex ff Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex 1 □ M 2 F Days Months Hours Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 7 is marked other than "naturel", or frems 23a or 28a-f show traumatic event, the Madical Examiner must be notified at MD Director n/a Baltimore 1√2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3611 E. Lombard St. 21224 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: American ð 3 Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker In own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleveland Brewer Attie Bullard ဥ 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Juanita Byrd 3611 E. Lombard St, Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn 11/28/ 05 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St.Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner ersion ettending physician end I for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hes 1 Yes 2 110 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medicai Certification: To 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Feath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hosp... within 24 hours eff 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 4575 NOV 22, 2005 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 01 Eistern Ave. B-1+, My 21220 cNobney 49 M ew. 32. Redistrar's Signature 31. Date filed (Month State 8 estain. Registrar

DHMH 16 Rev 6/95

ORIGINAL

| | | 1 - For State Registrar | State of Ma | arylar | | | | ealth a D <i>eath</i> | and M | - | giene | | 5 | 38036 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------|-----------------------------------|----------------------------------------|--------------------------|------------------------------|--------------------------|-----------------------------------|----------------------|------------------------|-----------------------|------------------------------------------------|
| Physici | an | 1. Decedent's Name (First, Middle, Las | t) | | | | | | | 2. Date of De Month | | , Y | ear | 3. Time of Death |
| /Media | cal | Mae E. Kellam 4a. Facility Name (If not institution, give | estroat and number) | | | 4h Cih | Town or | Location o | of Death | | 18 | County of | Dooth | 14:30 PM |
| Examir | ner | | | | | , | | | n Deall | | | 1; co | | |
| Funeral | | teninsula Region 5. Social Security Number 96. Se | 7. Age | | last birthday) | If Under | 1 Year | If Under 2 | 24 Hrs. | 8. Date of Birt | th | 0 | | lace (State or Foreign try) |
| Director | | 227-03-0570 | □M 2∏ F | 98 | Yrs. | Months | Days | Hours | Min. | (Month, Da Sept 28 | B, 19 | 907 | Virg | ginia |
| p , | | Usual Residence of Decedent 10a. State 10b. County | | 10c Cit | y, Town or Lo | cation | | | | | | | 1/ | 0d. Inside City Limits |
| ahov | 5 | MD Wicomic | 2 | 100.01 | Salis | | | | | | | | ' | 1 ☐ Yes 2 ☑ No |
| ith the Marylan or 28a-f ahow | Funeral Director | 10e. Street and Number | <u> </u> | | Salis | 10f. Zic | Code | | | | 10a Citi | zen of Wh | at Coun | |
| with with | <u></u> | 4759 Airport Road | I | | | | | 1804 | | | | USA | | ,- |
| death | era | 11. Marital Status | 12. Was Decedent I | Éver in U | .S. 13. V | Vas Dece | | | gin? (Spe | ocify Yes or No Rican, etc.) | - | 14. Race - | Americ | |
| after or ite | | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give | 10 | | r res, spe⊲ I⊡ Yes | | n, mexican Specify: | i, Puerto i | Hican, etc.) | | | White, | |
| Sours Frail. | d by | 3 ☐ Widowed 4 反 Divorced | Year or Dates: | | | 162 | 2 <u>14</u> 0 | эрөсну. | | | | Specify: T | VILL | е |
| natu | Completed | 15. Decedent's Ed (Specify only highest gra | ucation de completed) | | 16a. Deced | dent's Usua kind of wo DO NOT us | rk done d | durina most | t of worki | ng | 16b. Ki | nd of Busi | ness/Ind | lustry |
| withir then | m d | Elementary/Secondary (0-12) | College (1-4or 5 | +) | | | | , | | | do | | | atoro |
| Hygi ant. | | 17. Father's Name (First, Middle, Last) | | | | secre | cary | | r's Name | (First, Middle, | | | lent | store |
| yidning Z. I.Z. I.Z. O.Z. O.Z. O.Z. O.Z. O.Z. O | To Be | Robert Crosdale | Evans | | | | | (| Grace | e Watso | n | | | |
| and N | ļ- | 19a. Informant's Name/Relationship (7 | ype, Print) | | | | | | | I Route Numbe | | | ate, Zip | Code) |
| end 2 ealth m 27 | | Robert E. Kellam | Sr/son | | _ | | | Villis | | arf, VA | | | | |
| ages 1 ent of H. M: If Itel | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify | | 20b. F | Place of Dispos cemetery, crem | sition (Nar natory or o | ne of ther plac | θ) | D | ate | 20c. Lc | cation - Ci | ty or To | wn, State |
| politimote, Mail yialto Z. I.S. 13-10030 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Itam 27 Is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, If a Medical Examinat must be notified at ance. | | 21. Signature of Funeral Service Ucen | | cto | | Name ar ate n | | | bard 2120 | 655 W. | Ba1 | timoı | re S | treet |
| | | 23a. Part1. Enter the disease, or comp | olications that caused | the deat | | | | | | | rrest, | | | Approximate |
| Pnysician | 0 0 | shock, or heart failure. List only a | one cause on each iir | 10. | P | mo | 11.0 | | | | | | - Ji | Interval Between Onset and Death |
| /Medical | | disease or condition resulting in death) | a Due to (or as | a conseq | - | | VIII | | | | | | - | |
| Examiner | | Sequentially list conditions | b. ———— | | | | | | | | | | | |
| D is | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury | Due to (or as | a conseq | uence of): | | | | | | | | | |
| xecution and II-tran | хап | that initiated events resulting in death) Last | c Due to (or as | a consec | uence of): | | | | | | | | | |
| of CC, ate be executed obysicien and the buriat-transit | ical E | l | | | | | | | | | | | | |
| do difficate | edic | | 0 | | | | | | | | | | | |
| onding use | Z/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome 1 ☐ Live birth | | | Ectopic p | | | | | | 23d. Date o | of delive | ry |
| deatl deatle | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4☐Pregnant at | | | Other (sp | | | | | | Month | | Day Year |
| The COLORS, F.C. BOX 90100, The law requires that the death certificate be executed with heas been signed by the ettending physicien and bage 2 should be detached for use as the burial-transli | Physician/Med | 9 Unknown | | | 441 1 - 41 | | | | | 00. 8:41 | | | | |
| signe the d | | Part II. Other significant conditions of | | | ع و ع ا | Q | ause give | an in Pan i. | | 239. Did (| | | | e cause of death? |
| w requires the been signed should be | etec | | 1 | | | | | | | | | | - | |
| ne lav | ompleted by | | | | | | | | | 24a. Was autor perfo | | pric | r to con th? | osy findings available apletion of cause of |
| in: Ti ificete or. pa | ပိ | 25. Was case referred to medical | | | | | | ac Olasa | of Dooth | 1 ☐ Yes | _ | 1 | Yes | 2□ No |
| ysicia s cert | 0 | examiner? 1 ☐ Yes 2 ☑ No | Hospital: Inpatie | nt 2 | ER/Outpatien | t 3 DC | Othe | 200 | | ne 5 ☐ Resid | | S □Other | (Specify | •1 |
| e Ph ter th | n: T | 27. Manner of Death 1 Netural 5 □ Pending | 28a. Date of Injur (Month, Day | | 28b. Time of | | 28c. Injury Work | | | 28d. Describe l | | | , | , |
| eath. | catle | 2 ☐ Accident investigation | | | | М | | Yes 2□N | No | | | | | |
| tal or Att s after de al Diract ed in by t | Certification; | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injubulding, etc. | ury - At h c. <i>(Specil</i> | ome, farm, stre y) | eet, factor | y, office | | 1 | 28f. Location (3 City or Tox | | | or Rural | l Route Number, |
| To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2 | edicai | 29a. Certifier (Check only one) Certifying Ph 2 Madical Exam | ysician: To the best of inar: On the basis of and manner sta | examina | owledge, death tion and/or inv | occurred restigation | at the tim , in my of | ne, date and pinion, deat | d place, a th occurre | and due to the ed at the time, | cause(s) date and | and mann place, and | er as sta d due to | ated. the cause(s) |
| To ti To ti comp | ž | 29b. Signature and title of certifier | 11 | | | | | number | | | 29d. Dat | e signed (/ | Month, E | Day, Year) |
| | | 1 / hof / | 1 | | | | D34 | 57 | 6 | | | /10/ | 05 | |
| | | 30. Name and address of person who | completed cause of d | eath (Iter | n 23a) (Type, | Print) | | 4 | - / | (| 100 | | | |
| Ch | ate | | aVitz_ | ar's Signa | o t | arro | 11 -3 | 7: S | 2/15 | bury | m D | 之18 | 01 | |
| Regist | | 31. Date filed (Month, Day, Year) NOV 2 8 200 | 15 Best | , 10 | Goa | West of | | | | Ť | | | | |

DHMH 17 Rev 1/2001

937-03-0510

Mae Kellum

| | | | For State Registrar | State of M | laryland / | | artmen rtificat | | | and N | | giene | 005 | 38 | 037 |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------|---------------------|-----------------------------------------|---------------------------------|---------------------------|-----------|--------------------------------------------|------------------------------|------------------------|-----------------------------------------------|---------------------------------------|
| | Physic | an | 1. Decedent's Name (First, Middle, La | • | | | | | | | 2. Date of Dea | | Year | 3. Tim | ne of Death |
| | /Medi | cal | Leonard | | zoskie, | br. | | | | | NOVEME | BERE | 5, 200 | | : 12A M |
| | Examir | er | 4a. Facility Name (If not institution, gives Saint Joseph | n Medica | l Cent | | | | | Tows | | | unty of Deat | ltimo | ore |
| | Funeral Director | | | Sex 7. Ag 1 ☑ M 2 ☐ F | ge (In yrs. last i | Yrs. | Months | Days | Hours Hours | Min. | 8. Date of Birtl (Month, Day May 30, | h V. <i>Year)</i> 1925 | 9. Birti | hplace (Sta ountry) NSY1V | ate or Foreign |
| | D. | | Usual Residence of Decedent | | | | | | | | J / | | | , , <u>, , , , , , , , , , , , , , , , , </u> | 0,120 |
| | anylar show | 5 | 10a. State 10b. County MD Baltim | one | 10c. City, To | wn or L moni | | | | | | | | | e City Limits |
| | 28a-f | Funeral Director | 10e. Street and Number | | 11 | דו וטווו | 10f. Zip | Codo | | | | 10= 01: | -6.1461.0 | | Yes 2X No |
| | 3a or | ā | 2 Glenamoy Court | | | | | 2109 | ٦ | | | | of What Co | untry? | |
| | death ms 2 | nera | 11. Marital Status | 12. Was Decedent | Ever in U.S. | 13. | | | | gin? (Sp | ecify Yes or No- Rican, etc.) | | Race - Ame | | ٦, |
| 98 | within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-1 show its Mudical Examinar must be notified at | y Fu | 1 Never Married 2 Married | Armed Forces? 1 Yes 2 If Yes, Give | | | 1 Yes, spec | | n, Mexican Specify: | , Puerto | Hican, etc.) | | Black, White | | |
| Ö | hours tural', | ed by | 3 Widowed 4 Divorced | Year or Dates: | | | | | | | | | L | White | |
| 5 | in 72 n na n na | plete | 15. Decedent's E (Specify only highest gr. | ade completed) | | (Give | dent's Usua kind of wor DO NOT us | k done d | urina most | of work | ing | 16b. Kind (| of Business/I | Industry | |
| 212 | giene giene er tha | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | | Car De | aler | | | | Au | tomoti | ive | |
| Baltimore, Maryland 21215-0036 | 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show tamatic event, It a Mudical Examinar must be notified at | Be | 17. Father's Name (First, Middle, Last | Lozos | skie | | | | | r's Name | e (First, Middle, | Maiden Sur | name) Stanu | 10 | |
| Ž | should nd Me mark matic | င္ | 19a. Informant's Name/Relationship (| | | b. Maili | na Address | (Street a | | | al Route Number | r. City or To | | | |
| M. | and 2 alth a 27 is | | Leonard A. Lozosk | | חנ | 1504 | Rege | nt D | r., B | el A | Air, MD | 2101 | | <i>ip</i> C006) | |
| ore | of He of He if item or oth | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Removal from State | cemet | ery, crei | nsition (Name | her place |) | | | 20c. Locati | on - City or 1 | Town, State | 9 |
| Ē | Pag tment tant: | | 4 ☐ Donation 5 ☐ Other (Specification) | (y) | pacre | | | | | | | | alk, M | | |
| Ba | permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic e <u>once</u> . | | 21. Signature of Funeral Service Licer | nsee William | ı G. Da | | 2. Name and 1050 | d Address York | Rd., | Tou | k Towso Json, MD | n Fun 212 | | ome, | Inc. |
| П | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused one cause on each li | d the death. Do | not ent | ter the mode | of dying | , such as | cardiac o | or respiratory arr | est, | | | Between |
| 1 | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. SUBAF | RACHNO | ID | HEMOF | RHA | GE | | | | | | nd Death AY |
| | Examiner | | 1 | Due to (or as | a consequence | e of): | | | | | | | | | |
| ž | | er | Sequentially list conditions, if any, leading to immediate | b. — Uue to (or as | a consequence | 9 Of): | | | | | | | | | |
| | cuted or ransit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | C. | | | | | | | | | | | |
| Ö, | sate be executed bhysicien and the burial-transit | Ex | resulting in death) Last | Due to (or as | a consequence | e of): | | | | | | | | | · · · · · · · · · · · · · · · · · · · |
| 8760, | icate be executed physicien and s the burial-transit | dlcal | | _ d. | | | | - | | | | | _ | | |
| ox e | eath certific ettending p | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | of pregnancy | | | | | | | | | | |
| ĕ. | death e etter | clar | in the past 12 months? | 1□Live birth 4□Pregnant at | 2 Fetal deat | | Ectopic pre Other (spe | | | | | | Date of deliv Month | Day | Year |
| P.O. | that the de led by the detached | hys | 9 Unknown | 9□ Unknown | | | | | | | | | | | |
| Records, I | The law requires that the death certific sie hes been signed by the ettending p page 2 should be detached for use as | þ | Part II. Other significant conditions of | ontributing to death b | ut not resulting | in the u | nderlying ca | use giver | n in Part I. | | 23e. Did tob | | ontribute to t | | of death? ∐Unknown |
| မင္ပ | e taw re hes be je 2 sh | Completed | | | | | | | | | 24a. Was a | | b. Were auto | opsy finding | |
| | | | | | | | | | | | perform | | death? | 2□ No | a cause of |
| Vital | Phyeician: Th r this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | | 7 | | | (Check only on | | | | |
| ō | Phys arthis aral di | 5. | 1 ☐ Yes 2 🔏 No 27. Manner of Death | 28a. Date of Injur | ry 28b. | utpatien Time of | | | 4 Nuis | | ne 5 Reside 28d. Describe ho | | | fy) | |
| 0 | death. ctor: After y the funera | atloi | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Da) | y Year) | Injury | М | lc. Injury a Work? 1 🔲 Ye | r` ∋s 2∐N | | | , 2., 9 00. | ,uou | | |
| Division of | after death after death Director: d in by the | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injubuilding, etc | ury - At home, f c. (Specify) | arm, str | eet, factory, | office | | 2 | 28f. Location (Sti City or Town | reet and Nu I, State) | mber or Rur | al Route N | umber, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, | Medical C | 29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1 | ysicien: To the best of timer: On the basis of and manner sta | examination a | e, death | occurred a restigation, i | t the time in my opii | , date and nion, death | place, a | and due to the ca | ause(s) and ate and plac | manner as s | stated. o the cause | 9(s) |
| | To th Within To th compl | Me | 29b. Signature and title of certifier | 9 | 1 > | | 29c. | License | number | | 25 | 9d. Date sig | ned (Month, | Day, Year, |) |
|) | | | July | Tow 1 | n.O | | | D 2 | 4034 | | | 11/2 | 5/05 | 5 | |
| 10 | +11 | | 30. Name and address of person who | completed cause of de | eath (Item 23a) | (Туре, | Print) | | | | | 1.1 | 1 | | |
| U | 4 | | 31. Date filed (Month, Day, Year) | D 76.011 | OSLE F | R DE | VIVE_ | TOW | SON_I | MAR | YLAND 3 | 21204 | | | |
| 1956 V | Sta Registra | 1.0 | NOV 2 8 2005 | Jack Pagistra | D A | est. | P | | | | | | | | |

| Physici | | Decedent's Name (First, Middle HYMAN | , Last) | | | | LEI | 3SON | | 2. Date of D | | ž2 20č | | 3. Time of 7:15F | |
|----------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------|--------------------------------|------------------------------------|-----------------------|--------------------------------------|------------------------|-----------------------------------|------------------------|----------------------------|--------------------|---------------------------------|-----------|
| /Medi Examir | | 4a. Facility Name (If not institution | 3 |) | | | Town, or | Location | | | | . County of | Death | | |
| | | 8538 LUCERNE R 5. Social Security Number | | ge (In yrs. la | and himboland | RAN If Under | | _STOW | | 0 Date of B | 1-16 | BALTI | | | |
| Funeral Director | Н | 139-14-5831 | 100 M 2□F | 87 | Yrs. | Months | Days | Hours | Min. | 8. Date of Bi | 71918 | 3 | Coun | lace (State of try) | r r-oreig |
| ≵ ree | | Usual Residence of Decedent 10a, State 10b, County | | 10c City | , Town or Lo | cation | | | | | | | 1 | Dd. Ingido Cit | hed impli |
| nd Mental Hygiene marked other than "natural", or Items 23s or 28s-f show imatic event, the Modical Examinar must be notified at | ō | MD BALTI | MODE | | ANDALL | | | | | | | | ' | 0d. Inside Cit 1 ☐ Yes | • |
| r 28a- | Director | 10e. Street and Number | HOKE | 107 | NIVALL | 10f. Zip | | | | | 10g. Cit | izen of Wha | it Coun | try? | _^ |
| 23a o | aiD | 8538 LUCERNE R | OAD | | | 2 | 1133 | 3 | | | | U.S. | Α. | | |
| is marked other than "natural", or Items 23a or 28a-1 show eumatic event, the McCical Exam art must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced | 12. Was Deceden Armed Forces ed 1 17 Yes 2 1 If thes, Give Year or Dates: | ? INO WWI | T | Vas Deced fYes, spec I□Yes 2 | V | spanic Ori n, Mexicar Specify: | gin? (Spo n, Puerto | ecify Yes or N Rican, etc.) | 0- | 14. Race - Black, Specify: | White, 6 | | |
| dical | Completed | 15. Decedent (Specify only highes | | | 16a. Deced | kind of won | k done o | turina mos | t of work | ing | 16b. K | ind of Busin | ess/ind | lustry | |
| than than | mpi | Elementary/Secondary (0-12) | College (1-4or | 5+) | PHARM | OO NOT us | e retired, |) | | • | PHA | RMACE | HTT | ΓΔΙ | |
| ent, | O I | 17. Father's Name (First, Middle, I | _ast) | | | | | 18. Mothe | er's Name | (First, Middle | | | 011 | ONL | |
| tic ev | To B | MAURICE | | LI | EBSON | | | LI | BBY | | | Р | RYZ | ANSKY | |
| reum | Ľ | 19a. Informant's Name/Relationsh | | | | - | | | | Il Route Numb | | | | Code) | |
| or other treumatic | | PEARL LEBSON / 20a. Method of Disposition | WIFE | 20b. Pl | ace of Dispo | sition (Nam | e of | | | DALLSTO Date | _ | MD 21 ocation - Cit | | wn State | - |
| y or o | | 1 Burial 2 ☐ Cremation 4 Donation 5 ☐ Other (Sp | | ∍ MD ^{ce} | FRFF | PETATE | her place | T | | | Rose | dale | 120- | ini, cialo | |
| any injury o | | 21. Signature of Funeral Service L | | JEW. | ISH WA | Name and | ERAN Addres | S of Facilities | | /2005 LEVINS | | IMORE | | TNC | |
| any ir | | Dutt 11 | Cittle | | 189 | 00 RE | ISTE | RSTO | NN RI | DAD - F | PIKES | VILLE | . , | INC. D 2120 | 8 |
| | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that cause only one cause on each | ed the death line. | . Do not ente | er the mode | of dying | g, such as | cardiac o | r respiratory a | arrest, | | 3 | Approximate Interval Betv | veen |
| cian | | Immediate Cause (Final disease or condition resulting in death) | _a. Acute | M | yeloid | Lev | ken | 4.00 | | | | | | Onset and D | |
| ical ner | ı | resulting in dealth) | Due to (or as | s a consequ | nce of): | | | | | | | | | | |
| | je | Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury | b. Due to (or as | s a consequ | ence of): | | | | | | | | - | | |
| | Examiner | that initiated events | c | | | | | | | | | | | | |
| the burial-transit | EX | resulting in death) Last | Due to (or as | s a consequ | ence of): | | | | | | | | | | |
| s the t | dical | | d | | | | | | | | | | | | |
| for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | ı= | | | | | | 23d. Date of | delive | у | |
| tached for | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 Live birth 4 Pregnant a | | | Ectopic pre Other (spe | | | | | | Month | | Day Y | ear |
| | | 9 □Unknown Part II. Other significant conditio | - 300 | but not racu | Iting is the ur | dorhing on | use and | n in Port I | | 23e Did | tabacca : | ica cantribu | to to the | e cause of de | acth? |
| should be deta | d by | Coronary | | CISE | iting in the di | idenlying ca | use give | mili Falli. | | | Yes 2 | _ | | ıbiy 4 ∐U | |
| | lete | | J | | | | | | | 24a. Was | an | 24b. Wer | a auton | sy findings a | vailab |
| rector, page 2 | Completed | | | | | | | | | auto | psy ormed? | prior deat | to com h? | ipletion of ca 2 ™ No | use of |
| ClOi, | BeC | 25. Was case referred to medical | | | | | | 26. Place | of Death | (Check only | 2 No one) | _ '0 | 185 | 2 140 | |
| ral director, | 5 | examiner? 1 ☐ Yes 2 🔀 No | Hospital: 1 ☐ Inpati | | R/Outpatien | | | 4 140 | rsing Ho | ne 5 Hesi | idence | 6 □Other (| Specify |) | |
| unera | ion: | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of Inj (Month, Da | ury ay Ye <i>ar)</i> | 28b. Time of Injury | | C. Injury Work | | | 28d. Describe | how injur | y occurred | | | |
| completely filled in by the funera | ertification: | 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi | ot be 28e. Place of Ir | njury - At hor tc. <i>(Specify)</i> | me, farm, stre | M eet, factory, | | /es 2□ | | 28f. Location (City or To | Street an wn, State | d Number o) | r Rural | Route Numb | er, |
| oletely fille | edical C | 29a. Certifier 1 Certifying (Check only one) | g Physicien: To the best examiner: On the basis of and manner s | of examinati | vledge, death on and/or inv | occurred a restigation, | t the tim in my op | e, date an inion, dea | d place, a | and due to the ed at the time, | cause(s) date and | and manne place, and | r as sta due to | ited. the cause(s) | |
| com | Σ | 29b. Signature and title of certifier | M | | | 29c. | License | number | | | | e signed (M | | | |
| 9 | | Edlict K | theelle | ノ_ | | | 75-14 | 126 | | | Nou | eubz- | 2 | 3,200 | 5 |
| Y | | 30. Name and address of person v | 1 | death (Item | 11 | | | _ | , | 7 | <i>a</i> : | . 11- | | 3,200 | |
| | | 31. Date filed (Month, Day, Year) | 20. (d 90) | 20 C | | ort 1 | 20 | 20: | te | 301. 1 | /ilees | ville, | n | 1 | |

| | | 4 | For State of Maryland / Departr | ment of Health and I ficate of Death | Mental Hygie | | 38039 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------|----------------------------------------------------|
| I | Physici | | 1. Decedent's Name (First, Middle, Last) Aurealis J. Cash Morton | | 2. Date of Death |) Bay 20°65 | 3. Time of Death 2:45 PM |
| | /Medic Examin | | | b. City, Town, or Location of Deat Laurel | 1 | 4c. County of Death Prince Ge | <u> </u> |
| | Funeral Director | | Social Security Number 6. Sex 7. Age (In yrs. last birthday) If | f Under 1 Year If Under 24 Hrs. lonths Days Hours Min. | | 9 Right | place (State or Foreign |
| | D | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | on | 30, 20, 2 | - | Od. Inside City Limits |
| | the Mar 28e-f st cultied | Director | MD Prince George's Lanham | n 10f. Zip Code | 100 | . Citizen of What Cour | 1. Yes 2 No |
| | 3a or | | 8649 Cipriano Springs Court | 20706 | 109 | USA | my: |
| | death | nera | | s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerl | pecify Yes or No- | 14. Race - Americ Black, White, | |
| 39 | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other then "natural", or items 23s or 28e-f show other treumatic event, the Medical Examiner must be notified at | by Funeral | 1 Never Married 2 Married 1 Yes 2√2 No | Yes 20 No Specify: | 7 110211, 510.7 | Specify: Bla | |
| Maryland 21215-0036 | 72 hou | Completed | 15. Decedent's Education 16a. Decedent' (Specify only highest grade completed) (Give kind | t's Usual Occupation d of work done during most of work NOT use retired) | rking 16 | b. Kind of Business/In | dustry |
| 7121 | l within lene. r then | omp | Elementary/Secondary (0-12) College (1-4or 5+) File C | · | | JS Govern | ment |
| pu | ai Hyg I other | BeC | 17. Father's Name (First, Middle, Last) | 18. Mother's Nar | ne (First, Middle, Mai | iden Sumame) | |
| yla | J Ment J Ment narked natic e | P | William Cash 19a. Informant's Name/Relationship (Type, Print) 19b. Maijing Av | | ine Butl | | 0-13 |
| | ulth and 2 shall the and 27 is n | | | oddress (Street and Number or Ru Glen Willow + | | | Code) |
| Baltimore, | of Head of Head of Head of Head of Item | | 20a. Method of Disposition 1 | itol Heights, on (Name of ory or other place) | Date 200 | c. Location - City or To | own, State |
| ţ | t. Pag tment tent: I tjury o | | '4 □ Donation 5 □ Other (Specify) Harmony M | | | Landove | |
| Ba | permit. Pages 1 a Department of He Importent: If Item any injury or othe | | Molph William Lat | ame and Address of Facility tney's Funera | 1 Home W | ash., DC | Ave., N.W 20011 |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | or respiratory arrest, | | Approximate Interval Between Onset and Death |
| | Pnysician /Medical | | disease or condition resulting in death) Metastatic Color Due to (or as a consequence of): | on Cancer | | | |
| | Examiner | _ | Sequentially list conditions, b. | | | | |
| | ned I | Examiner | if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. (Disease or injury | | | | |
| Ő, | icate be executed physician and s the burial-transit | Exa | that initiated events resulting in death) Last C Due to (or as a consequence of): | | | | |
| 38760, | icate b physic s the b | dical | d | | | | |
| Box 6 | h certif ending use a: | in/Me | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect | topic pregnancy | | 23d. Date of delive | ry |
| o. | that the death certifii ed by the attending I detached for use as | Physician/Me | | her (specify) | | Month | Day Year |
| ds, P | Se us | by | Part II. Other significant conditions contributing to death but not resulting in the under | lying cause given in Part I. | 23e. Did tobac | co use contribute to the | e cause of death? ably 4 Unknown |
| Records, | e law requir has been si ie 2 should | Completed | | | 24a. Was an autopsy | 24b. Were auto | psy findings available inpletion of cause of |
| | | | | | performed 1 ☐ Yes 2 ☐ | death? No 1 ☐ Yes | 2 🗆 No |
| Vital | SS | o Be | 25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 | Other | ath <i>(Check only o</i> ne) Iome 5 □ Residenc | e 6 □Other (Specify | 7) |
| on of | ding h. Aftel fune | tlon; T | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury | 28c. Injury at Work? M 1 Yes 2 No | 28d. Describe how | | , |
| Division of | l or Attending after death. Director: Afte in by the fune | Certification; | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify) | factory, office | 28f. Location (Stree City or Town, S | et and Number or Rura State) | I Route Number, |
| _ | To the Hospitel or At within 24 hours after on To the Funerel Direct completely filled in by | edical C | 29a. Certifier (Check only one) 1 Sertifying Physionan: To the less of my knowledge, death occ 2 Medical Examiner On the basis of examination and/or investigated and manner stated. | curred at the time, date and place igation, in my opinion, death occu | , and due to the caus rred at the time, date | e(s) and manner as st and place, and due to | ated. the cause(s) |
| | To the within To the comple | Med | 29b. Signature and title of cardifier | 29c. License number | 29d. | Date signed (Month, I | Day, Year) |
| 1 | 4 | | · VIREIUS | 11043321 | 1 | 1/10/05 | |
| - | <u> </u> | | 30, Name and address of person who completed cause of death (Item 23a) (Type, Print DY-IKechi, Recloku ARA 6201 Creenh | ect Rd, Suite u | -15 College | PK MD | 20740 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 8 2005 32. Registrar's Signature. | ect Rd, Soute u | | | - |

| | | | For State | State of Maryland | | tment of I | | - | 200 | 5 20010 |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------|--------------------------------------|--------------------------------------|------------------------------------------|--------------------------|------------------------------------------------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Certi | iicale ui | Dealii | 2. Date of Dea | Reg. No. U | 3. Time of Death |
| 3. | Physicia | | ADA DELORES | MARSHATI | | | | Novemb | Day 20 1 | (Y)5 1:15 am |
| y | /Medic Examin | 20 | 4a. Facility Name (If not institution, give s | | 4 | b. City, Town, | or Location of De | | 4c. County | of Death |
| *** | | | Maryland Gene | ral Hospita | | baltu | more (| ity | | N/A |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age\(In yrs. /a | | If Under 1 Year Months Days | | | h y, Year) /1020 | 9. Birthplace (State or Foreign Country) MARYLAND |
| 20.7 | Director | | 214-26-1497 Usual Residence of Decedent | | | | | 05/20 | 7 1929 | MAKILAND |
| | nylano how | | 10a. State 10b. County | | Town or Local | tion MORE C | TMV | | | 10d. Inside City Limits Yes 2 ☐ No |
| | Ba-f s | Director | MD N/A | | DALITI | | | | | |
| | should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or liems 23a or 28a-f show matic event, the Modical Examinar must be molifled at | | 10e. Street and Number 4018 BARRINGTO | N ROAD | | 10f. Zip Code 21 | 207 | | 10g. Citizen of W USA | vhat Country? |
| | r deat | Funeral | Tr. Markar Grand | 2. Was Decedent Ever in U.S Amed Forces? | i. 13. Wa | s Decedent of es, specify Cub | Hispanic Origin? ban, Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | | e - American Indian, k, White, etc. |
| 36 | rs afte | by Fi | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: | 15 | ∃Yes 21X No | Specify: | | Specify | BLACK |
| Ş | 2 hou | ted I | 15. Decedent's Educ | ation | 16a. Deceder | nt's Usual Occu | pation | | 16b. Kind of Bu | siness/Industry |
| 215 | thin 7 | Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life. DC | NOT use retire | during most of v | vorking | | MENT OF |
| 2 | filed wi Hygien Sther th | | 12TH 6 | | CASE | WORKE | | lame (First, Middle, | | SERVICES |
| and | id be fi ental H ked of | To Be | CLARENCE E. POV | ELL, SR. | | | AMANI | | Maldell Sumani | <i>θ)</i> |
| Maryland 21215-0036 | 2 2 2 2 | - | 19a. Informant's Name/Relationship (Ty) | . , | | | | Rural Route Numbe | | State, Zip Code) , MD 21239 |
| | ges 1 and t of Health if Item 27 or other to | | 20a. Method of Disposition | 20b. Pla | ace of Dispositi | ion (Name of | | Date | | City or Town, State |
| timore, | Pages nent of int: if it iry or o | | Marial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State MD | NATL | MEM P | ARK 111 | /26/05 | LAUREL | , MD |
| Balti | permit. Page Department of Important: fi any injury of once. | | 21. Signature of theral Service License | A. Dan | | Name and Addr | | | | L HOME 21207 ALTIMORE, MD |
| | | | 23a. Fact Enter the disease, or compli | cations that caused the death | | | | | | Approximate |
| Sept. | Physician | | Shock, or heart failure. List only or Immediate Cause (Final disease or condition | e cause on each line. | | | | | | Interval Between Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a consequent | ence of): | 0 | | | | |
| | Examiner | _ | Sequentially list conditions, | Metasta Due to (or as a consequence) | asis | 0+ O | larian | Cance | (| |
| | nsit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseque | erice or). | | | | | |
| Ć, | execu an and rial-tra | Exal | that initiated events cresulting in death) Last | Due to (or as a conseque | ence of): | | | | | |
| 8760, | icate be executed physician and s the burial-transit | Ical | | | | | | | | |
| 9 | as a | Med | IF FEMALE: | 3c. If yes, outcome of pregnan | | | | | | |
| Вох | death certific e attending p id for use as t | Physician/Medical | in the past 12 months? | 1 Live birth 2 ☐ Fetal 4 Pregnant at time of de | death 3□E | ctopic pregnand Other (specify) _ | су | | 23d. Dati Mor | e of delivery nth Day Year |
| P.O. | D 0 0 | hysi | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 9□ Unknown | | | | | | |
| | The law requires that the death certale hes been signed by the attendingage 2 should be detached for use | by P | Part II. Other significant conditions cor | tributing to death but not resul | lting in the und | ertying cause g | ven in Part I. | | | ribute to the cause of death? |
| ord | w require been si should l | ted | | | | | | - 101 | res 2□No | 3 Probably 4 Hunknown |
| Sec | elawı hesby je2st | Completed | | | | | | 24a. Was autop | osy p | Vere autopsy findings available prior to completion of cause of leath? |
| a F | | | Toe W | | | | | 1 ☐ Yes | 2 1 No 1 | ☐ Yes 2☐ No |
| ⋚ | s certi | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | ospital: | R/Outpatient | 3 DOA O | hor | Death Check only on Home 5 Resid | 100 | er (Snecify) |
| 1 of | Attending Physician: r death. ector: After this certifici by the funeral director. | | 27. Manner of Death | | 28b. Time of Injury | 28c. Inii | | | now injury occurr | |
| į | ttending f death. stor: After the funer | atio | 1 Natural 5 Pending 2 Accident investigation | (0.01,011,011,011,011,011,011,011,011,011 | ,, | | Yes 2 No | | | |
| Division of Vital Records, | al or Atten a after deat I Director: d in by the | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At hor building, etc. (Specify) | me, farm, stree) | t, factory, office | | 28f. Location (5 City or Tov | | er or Rural Route Number, |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical C | | sician: To the best of my knowner: On the basis of examinati and manner stated. | | | | | | |
| | To the within 2. To the I complet | Me | 29b. Signature and title of certifier | | | 29c. Licer | ise number | | 29d. Date signed | i (Month, Day, Year) |
| | | | Africa de m | D. | | 89 | 573 | | 11-20 | 0-05 |
| | 8 | | | mpleted cause of death (Item | 23a) (Type, Pr | rint) | - 1 11 | 1 | | |
| 000 | 0 | to. | 31. Date filed (Month, Day, Year) | 32. Begistrar's Signati | yland | vere | rai Hos | pital | | |
| 466 | Sta Regist | | NOV 2 R 70 | | & Som | 282 | | 3 | | |

State of Maryland / Department of Health and Mental Hygiege, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 7:00 p.m William S. November 22, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. St. Martin's Home - Little Sisters of the Poor Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Binh (Month, Day, Year) Oct. 28, 1 6. Sex 1X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 532-44-1825 100 New York 1905 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Co. Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 United States 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Seminary Elementary/Secondary (0-12) Roman Catholic Priest Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ... Pages 1 and 2 should be fill timent of Health and Mental H tant: if item 27 is marked ott hiury or other traumatic even Be William Edward Morris Anna Bernadette Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Ronald D. Witherup - Fellow Priest 5408 Roland Avenue Baltimore, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o once. Nov.30,2005 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Sulpician Cemetery 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road 1.6.1 Leonard J. Ruck, Inc. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NO Sel **Physician** disease or condition resulting in death) /Medical **Examiner** ATIUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed tran that initiated events resulting in death) Last Due to (or as a consequence of) the burial-Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 0 Month Day Year 4☐Pregnant at time of death 5 Cther (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has ate 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation after death Director: / 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 2 arke Name and address of person who completed cause of death (Item 23a) (Type, Print) 345+ Wilkens AT. BALTIMCRE. MD 21229 BASKARAN Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November Kunjunjamma 8:15 р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. April 24, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1935 Months Days 1 ☐ M 2 🏝 F 227-89-4796 70 Kerala, India Director Usual Residence of Decedent with the Maryland r 28a-f show a notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai', or items 23a or Examiner must be 13826 Tabiona Drive 20906 India Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Asian 1 ☐ Yes 2 No δ 3 Nidowed 4 Divorced "natural" Completed other than "natur 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Occupation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Varkey Thomas Achamma Thomas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Thomas Mammen/Son 13826 Tabiona Drive Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of P important: If Ite sny Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/02/2005 4 □Donation 5 □ Other (Specify) Kilpauk Cemetery Tamil-Nadu 21. Sign, ture of Francial Service Licensee 22. Name and Address of Facility Fleck Funeral Home ion 7601 Sandy Spring Rd Laurel, Md 20707 WI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Exam resulting in death) Last Due to (or as a consequence of) Physician/Medical as use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Uterine Prolapse been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Millitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t 1 Yes 2☐No 1 Yes 2 No Attending Physician: director Be 25. Was case referred to medicaf examiner? 26. Place of Death (Check only one) Hospital: 1 🙀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA eral Diractor: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturaf 5 Pending death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DR0063579 25/2005

State Registrar

Maria J Tayag, MD 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 🖁 32. Registrar's Signature NOV 2 8 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

| | | | 1 - For State Registrar | State of M | aryland / De | partment ertificate | | | lentai Hy | giene | 05 | 38043 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------|-------------|--------------------------------------|-----------------------------------------------------|------------------------------|---------------------------------------------------|
| 5 . | Physic /Medi | | 1. Decedent's Name (First, Middle, Last Allene Car | | | Mille | er | | 2. Date of De Month Novembe | eath | 00 ^{Year} | 3. Time of Death 10:25 PM |
| 1 34 | Exami | | 4a. Facility Name (If not institution, give Washington Advent | , | | | own, or Location na Park | | | 4c. Cour | tgome: | |
| - SE | Funeral Director | 11:2 | 243-30-3413 | 7. Aç | ge (In yrs. last birtho 82 Yrs | Months F | Year If Under Days Hours | Min. | 8. Date of Bi (Month, Di Dec 3 | rth ay, Year) 1922 | Cou | place (State or Foreign ntry) th Carolina |
| | Maryland | tor | Usual Residence of Decedent 10a. State 10b. County NC Wake | | 10c. City, Town o | | | | | | | 10d. Inside City Limits |
| | h with the | al Director | 10e. Street and Number 409 Walton Street | | | 10f. Zip Co | 7610 | | | 10g. Citizen o | | ntry? |
| 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show says injury or other traumatic event, the Medical Exams and must be recitled at ODGE. | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates: | | 3. Was Deceden If Yes, specify 1 ☐ Yes 2X | nt of Hispanic Or Cuban, Mexica | | cify Yes or No Rican, etc.) |)- 14. Ra | ace - Ameri ack, White, | etc. |
| 21215-0036 | d within 72 ho giene. ir then "natur the Medical | Completed | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2 | | 5+) (G lif | cedent's Usual C ive kind of work of a. DO NOT use i shier | Occupation done during mos retired) | st of worki | ng | 16b. Kind of | | dustry |
| Maryland | ould be file Mental Hyg tarked oths | To Be C | 17. Father's Name (First, Middle, Last) John Carter | | | | Res | sie N | Nash | , Maiden Suma | ime) | |
| | 1 and 2 sh Health and tem 27 is m | | 19a. Informant's Name/Relationship (Ty Ruth C. Wallace - 20a. Method of Disposition | | | ailing Address (S 29 30th | Street | NW V | | | 2001 | .5 |
| Baltimore, | mit. Pages partment of cortant: If I injury or e | | 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License | | cemetery, c | rematory or other Nation | al Cem | 11-1 | 4-05 | Ralei | _ | |
| a A | permi Depa Impo any ii | | 23a. Part. Enter the disease or complisheck, or heart failure. List only or | cations that caused | the death. Do not | 22. Name and A Haywood 2415 S. | Wilming | gton | St. Ra | leigh, | NC 27 | 603 Approximate |
| * | Physician Medical Physicien and | dicai Examiner | Inhmediate Caluse (Final disease or condition resulting in dealh) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiliated events resulting in death) Last | Due to (or as | a consequence of): a consequence of): a consequence of): | OMA | A (5 | SL | A DI | DER | | Onset and Death |
| O. Box 6 | death certi e attending id for use a | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown | 3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal death | B Ectopic pregn | | | | | ate of delive | ory Day Year |
| ords, P. | law requires that the as been signed by th 2 should be detache | ρ | Part II. Other significant conditions con | tributing to death b | ut not resulting in the | underlying caus | e given in Part 1. | 7 | 23e. Did to | | | ne cause of death? |
| Division of Vital Records, | The ate h page | e Completed | 25. Was case referred to medical | | | | | | 1 ☐ Yes | rmed? 21 No | Were autopprior to condeath? | psy findings available inpletion of cause of 2 No |
| 5 | Physician this certail direct | To B | examiner? | ospital: 1 K Inpatie | nt 2 ER/Outpat | | Other: 4 Nu | rsing Hom | | lence 6 Oti | | ') |
| 'Ision | or Attending I after death. Director: After in by the funer | Certification; | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | (Month, Day | Year) Injury | М | Injury at Work? 1 Yes 2 1 | No | | ow injury occur | | |
| 2 | urs urs eral | | 4 Homicide determined 29a. Certifier 1 Certifying Phys | building, etc | :. (Specify) | | | | City or Tow | n, State) | | l Route Number, |
| | To the Hos | Medical | (Crick only one) 2 Medical Examination Medical Examination (Crick only one) 29b. Signature and title of certifier | er. On the basis of and manner sta | TOWNS HOUSEHINGAN | investigation, in r | my opinion, deat | h occurred | d at the time, o | ause(s) and m date and place, 29d. Date signe | and due to | the cause(s) |
| | | | Duela U | u O | That The sale of the | | USL | 190 | | 11 | 7/0 | 2 |
| 5 |) | | 30. Name and address of person who cor Yudh Gupta, MD 7 31. Date filed (Month, Day, Year) | 600 Carro | 11 Ave. | Takoma | Park, MI | 02001 | 2 | | | |
| 74 | Star Registra | _ | NOV 2 2 2005 | Age Hegistra | r's Signature | DAMP A | | | | | | |

ORIGINAL

| | | | 1 - For State Registrer | State of | Maryla | | artmen rtificate | | | and M | lental Hyg | giene | 0.5 | 3801.1. |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------|-----------------------------------|-----------------------------------------|----------------------|---------------------------|-----------------------|-------------------------------------------|-----------------------------------------|-------------------------------|-------------------------------------|
| П | Physic | an | Decedent's Name (First, Middle, Las | • | _ | | | | | | 2. Date of Dea Month | | Year | 3. Time of Death |
| | /Medi | cal | Erik 4a. Facility Name (If not institution, give | L. Miche | _ | | 45 005 | . | 1 | (D 1) | Novemb | | 2005 | 2:30 P M |
| | Examir | ner | 5868 Thunderhill | | | | | olumi | Location o | or Death | | | ty of Death ward | |
| , | Funeral | | 5. Social Security Number 6. Se | × 7 | | last birthday) | If Under | 1 Year | If Under a | | 8. Date of Birth | | | ace (State or Foreign |
| | Director | | 212 68 1916 Usuel Residence of Decedent | X M 2□F | 51 | Yrs. | Months | Days | Hours | Min. | 8. Date of Birtl (Month, Day NOV 4, | 1954 | Mar | yland |
| | 72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show disal Exeri iner must be rodified at | | 10a. State 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | | 10 | Od. tnside City Limits |
| | e Ma | Director | MD Howar | d | C | olumbia | aa | | | | | | | 1 ☐ Yes 2 🕍 No |
| | with th | | 10e. Street and Number | | | | 10f. Zip | | | | | 10g. Citizen of | | * |
| | eath ve 23 | eral | 5868 Thunderhill 11. Marital Status | Road Apt | | 10 12 1 | | L045 | | 1.0.00 | | | ed Sta | |
| 10 | r Item | Funeral | 1 Never Married 2 Married | Amed Ford | es? | 7.5. | f Yes, spec | rify Cubar | n, Mexican | gin? (Spe , Puerto | ecify Yes or No- Rican, etc.) | | ce - America tck, White, e | |
| 03 | ral', o | þ | 3 Widowed 4 Divorced | If Yes, Give | es: 1984 | -88 | 1 ☐ Yes 2 | No 🔀 | Specify: | | | Speci | ^{⁄y:} Whi | te |
| 5-0 | 72 h | Completed | 15. Decedent's Edu (Specify only highest grad | ication le completed) | | 16a. Deced | dent's Usua kind of wor DO NOT us | l Occupa k done d | ition uring most | of worki | na | 16b. Kind of E | Business/Ind | ustry |
| 121 | within lene. then | mp | Elementary/Secondary (0-12) | College (1-4 | for 5+) | | | | | | | 7772-3 | 7 David | |
| d 2 | filed Hygir other | | 17. Father's Name (First, Middle, Last) | 3 | | sec | curity | Guc | | r's Name | (First, Middle, | Allied | | on |
| lan | Ald be dental | To Be | Paul Frederick Mi | chelsen | | | | | | | Mohler | | ···- <u>-</u> / | |
| Maryland 21215-0036 | nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ordernent of Health and Mental Hygiene. ordents if item 27 is marked other then "natural", or iteme 23s or 28s-f show injury or other treumatic event, the Madical Exprinite must be notified at a. | | 19a. Informant's Name/Relationship (7) | | | | | | | | / Route Number | | | |
| | and lealth m 27 her tr | | Kristine M. Laken | an/Siste | | | | | | manufacture in the | Ellicot | t City, | MD 2 | 1042 |
| Baltimore, | Pages 1 nent of P int: If ite iry or ot | | 20a. Method of Disposition 1 Derial 2 Cremation 3 DF | | ate 206. | Place of Dispo- cemetery, crem | sition (Nam natory or ot | e of her place | 1 | | | 20c. Location | | , |
| Ħ | permit. Pages Depertment of Important: If i eny injury or once. | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens | | | etro Cr | | | | | 3-2005 | | | |
| Ba | Depermine only in some | | Day Collin | - m | M01 | 044 22 | 12 01 | 7 Cc | -1 1 mb | Har: | ry H. W. | itzke's | Fami | ly FH Inc. MD 21043 |
| | | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only o | ications that cau | ised the dear | | | | | | | | | Approximate |
| | Physician | | Immediate Cause (Final disease or condition | No cause of said | VFR | (100 | HOS | 35 | , | | | | | Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or | as a consec | quence of): | | | | | | | | |
| ş. | | Li di | Sequentially list conditions, | Distriction | as a c 0.15e0 | ura e de | | | | | | | | |
| 7 | uted 1 Insit | Examiner | Sequentially list conditions, if any, leading to humadiate cause. Enter Underlying Cause (Disease or injury | 00010 (01 | - d3 & C0.1380 | juei los ciy. | | | | | | | | |
| o î | exection and rial-tra | Exa | that initiated events resulting in death) Last | Due to (or | as a consec | quence of): | | | | | | | | |
| 8760, | icate be executed physician and s the burial-transit | Ical | | d | | | | | | | | | | |
| × 68 | entifica ling pt | Med | IF FEMALE: | | | | | | | | | | | 227 |
| Вох | eath certific attending pi | lan/ | 23b. Was decedent pregnant in the past 12 months? | | h 2 🗆 Feta | ildéath 3⊡ | Ectopic pre | | | | | | te of deliver | / Day Year |
| P.O. | The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as i | Physician/Me | 1 □ Yes 2 □ No 9 □ Unknown | 4⊟Pregnar 9⊟Unknow | nt at time of o | leath 5∐ | Other (spe | cify) | | | | | , mi | ay (da) |
| ď. | res thet igned b be deta | by Pr | Part II. Other significant conditions con | ntributing to dea | th but not res | ulting in the un | derlying ca | use giver | n in Part I. | | 23e. Did tob | acco use con | tribute to the | cause of death? |
| rds | w require been sig should b | | | | | | | | | | 1 □ Ye | s 2 No | 3 Proba | bly 4 Unknown |
| ecc | faw requasis been 2 should | Completed | | | | | | | | | 24a. Was a | | Were autops | y findings available |
| <u>~</u> | | Соп | | | | | | | | | autops perform 1 Pes 2 | ned? | death? | otetion of cause of No |
| <u> </u> | Attending Physician: Thirdeath. ector: After this certificate by the funeral director, pag | Be | 25. Was case referred to medical examiner? | lospital: | | | | | | | (Check only on | | | |
| ō | Phys | . To | 1 Yes 2 No | 1 U Inp | | ER/Outpatient 28b. Time of | | | 4 🗀 14013 | | ne 5⊠ Reside 8d. Describe ho | | | |
| ion | nding I ath. r: After e funer | atlor | 1 Natural 5 Pending 2 Accident investigation | 28a. Date of (Month, | Day Year) | Injury | м | c. Injury a Work? | on es 2 □ N | | 00. D0301100 110 | w injury occur | 160 | |
| | or Attenated or Attenated Director: | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of | Injury - At he etc. (Specif | ome, farm, stre | et, factory, | office | | 2 | 8f. Location (Str | reet and Numb | er or Rural i | Route Number, |
| ۵ | ital or A irs after rel Direc lled in by | | | | | | | | | | City or Town | ŕ | | |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | edical | 29a. Certifier 1 X Certifying Phys (Check only one) 1 | ier: On the basi | s of examina | wledge, death tion and/or inv | occurred a estigation, i | t the time | , date and nion, death | place, a | nd due to the ca d at the time, da | use(s) and ma | anner as stat | ed. ne cause(s) |
| | o the o the omple | Med | 29b. Signature and title of certifier | and manner | stated. | | | License | | | | d. Date signe | | |
| } | r s r o | | * KNotely | /ww | | | 1 |)55 | 398 | 07 | | Nov. 2 | | |
| | ih | | 30. Name and address of person who so | mpleted cause | of death (Item | 1 23a) (Type, F | Print) | 121 | 11/2 | 7/ | CITAL | 2 411 | 2, 200 | |
| | 12 | | 390 ARNURY 1 | 4 Sui | lt 3 | 10 | altim | Ske | E K | 2 | 1507 | *************************************** | | |
| | Sta Registra | | 31. Date filed (Month, Day, Year) | 32. Reg | istrat's Signa | ture | Coon | No. 1 | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No.

Physician /Medical **Examiner**

Funeral Director

with the Maryland r than "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at filed within 72 hours after death permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once.

> Physician /Medical Examiner

The law requires that the death certificate be executed burial-transit and anding physician ause as the burial or Attending Physician: this After the Director: filled in by within 24 hours a

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year FSTHER MERWITZ 2005 7.10 A.M November 25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 03/24/1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 YF 90 215-10-3221 MD Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No BALTIMORE BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8911 REISTERSTOWN ROAD 21208 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **BOOKKEEPER** JEWISH CHARITIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AUSTER HELLER **JOSEPH** ELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 332 BONNIE MEADOW CIRCLE - REISTERSTOWN, MD 21136 DIANE POSTOL / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BNAI ISRAEL CONG. 11/27/2005 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Fund Service Licensee SOL LEVINSON & BROS., INC. ay 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disea learn complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearl failure. List only one cause on each line. Immediate Caus: (Final disease or condition resulting in death) lic encenhaloathis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ enting 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 Ho Certification: To 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 1)54288 Jovense, 25 Morthwes Hoppilal Cente 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Dangarajan Kamawany

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAMES Η. NEWMAN 23, NOV. 2005 /Medical 5:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6028 LOCH RAVEN BLVD. BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 03/20/1919 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 86 1**X** M 2□ F 220-09-9987 Yrs. Director MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 10d. Inside City Limits the Mudicul Examiner must be notified at Director MD N/A1 Yes 2 □ No BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 3907 ROSECREST AVENUE 21215 or items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Hygiene. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itan 27 is marked other than "na any injury or other traumatic event MARYLAND DRYDOCK Elementary/Secondary (0-12) College (1-4or 5+) SPECIALIST 6ТН CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARCHIE NEWMAN EVELYN NUTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 DRUID HILL AVE., CAROLYN COBB / DAUGHTER BALTIMORE, MD 21217 20b. Place of Disposition (Name of crematory crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEM. PK. 12/01/05 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CO., MD 22. Name and Address of Facility 21. Signature HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner armany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed engeline resulting in death) Last burial-1 Due to (or as a consequence of): P.O. Box 68760. thet as esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 3 Probably 4 □Unknown 1 Yes 2 No Stala 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Come resech 1 ☐ Yes 2 ☐ No 25. Was case ferred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 6 Other (Specify) HOSPILE nours after death.

naral Director: After this filled in by the funeral di 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medical CertIfication; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Me dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D31414 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EVITAW ST Suite 308 MD A. HASHMIMD. BAUTIMONE 2/201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 **Physician** Month Day 24 Nov. Anna B. Newsome /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cromwell Center Baltimore Baltimore 8. Date of Birth (Month, Day, May 15 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M **¾**□F Director 219-12-9304 Yrs. 82 1923 MAryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-1 shov 10d. Inside City Limits traumatic event, the Medical Examiner roust be notified at Director MD Baltimore 1 ☐ Yes 2 ☐ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1637 Frenchs Ave. or Items 23a 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No 3 ☑ Widowed 4 □ Divorced "natural, White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, It e Maury or other traumatic event, It e Maury or other traumatic event, It e Ma Elementary/Secondary (0-12) College (1-4or 5+) Epstein Salesperson 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grover Bangs Ella Simmons ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Trimble /daughter 1306 Wilson Point Road Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. HollyHillCemetery 11/29/05 Baltimore MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License e 22. Name and Address of Facility CONNETTY TO THE STATE OF THE PROPERTY OF THE STATE OF THE ConnellyFuneralHomeofEssex 23a. Part1. Enter the disease, or coshock, or heart failure. List of the shock of t mplications that caused the death. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed?
Yes 2 No 1 Yes 2 No 1 Tyes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 vursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type, Print) sistrar's Signature State

Registrar

George Niskach 05-AKG

| -77 | 81 | | 1- For Unpend Ite | State of Mem 23a&27 pe | Maryland/Deper me G849 | artment of H | lealth and | Mental Hy | giene U | 15 | 38048 |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------|
| 3 | | | Registrar 1. Decedent's Name (First, Middle | | | Tuncate of I | Dealli | 2. Date of De | ath | | 3. Time of Death |
| | Physic /Medi | | George | , | | Niskac | :h | November 1 | er 18, 2 | 2ďď5 | 2:08 P M |
| | Examir | | 4a. Facility Name (If not institution 1008 Beards Hil | | 115 | 4b. City, Town, or Aberdeen | | | 4c. County | of Death | |
| 2 | Funeral Director | | 5. Social Security Number 153–30–9267 | 6. Sex 7. 1 ☑ M 2 ☐ F | Age (In yrs. last birthday) 67 Yrs. | ff Under 1 Year Months Days | If Under 24 Hrs Hours Min. | | th | 9. Birthp Coun | lace (State or Foreign stry) Jersey |
| Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinat | To Be Completed by Funeral Director | Usuaf Residence of Decedent 10a. State 10b. County FL Flagle 10e. Street and Number 58 Evans Drive 11. Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 15. Decedent (Specify only highest Period only highest Period only highest Period only highest Period Niskach 17. Father's Name (First, Middle, George Niskach 19a. Informant's Name/Relations Judith Niskach | 12. Was Decede Armed Force 1 | 1956 to s: 1960 16a. Dece (Give life. Me | | ation furing most of word 18. Mother's Nar Mary Ga and Number or Ru | rking me (First, Middle, aza ural Route Numbe | Specify 16b. Kind of Bi Manufa Maiden Suman | What Coun be - Americ ck, White, Wh: Wh: usiness/inc cturi | an Indian, atc. ite dustry |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra | | 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S. 21. Signature Funeral Service 23a. Parl. Efter the disease, or | 3 □Removal from Sta | Putnam (| sition (Name of natory or other place Crematory 2. Name and Addres raig Flag 11 Old Ki | 11- s of Facility ler Palm ngs Rd. | 23-05 s Funera South, I | Interion Interior Interior | lache | |
| 68760, | Physician physician and physician and physician and physician and physician sthe purial-transit | dical Examiner | shock, or heart failure. List the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a Atheros Due to (or a b Due to (or a | sclerotic Ca as a consequence of): as a consequence of): as a consequence of): | rdiovascu | ılar Dise | ease | | | Interval Between Onset and Death |
| P.O. Box 6 | t the death certifi by the attending ached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown | 2 Fetal death 3 at time of death 5 | Ectopic pregnancy Other (specify) | | | 23d. Dat Moi | e of deliver | ry Day Year |
| | w requires that been signed should be det | þ | Part II. Other significant condition | ns contributing to death | but not resulting in the u | nderlying cause give | n in Part I. | 23e. Did to | | | e cause of death? |
| al Records, | : The law recate has be page 2 she | Completed | | | | | | 24a. Was a autop perfor | mea? c | leath' | sy findings available pletion of cause of |
| Division of Vital | Attending r death. •ctor: After by the fune | Certification: To Be | 25. Was case referred to medical examiner? **PXYes** 2 No 27. Mapner of Death 1 **ENatural** 5 Pendin. 2 Accident investig 3 Suicide 6 Could r. 4 Homicide | ation of be 28e. Place of I | jury 28b. Time of | 28c. Injury Work M 1 Y | r: 4 ☐ Nursing H | th Check only or ome 5 Resid 28d. Describe h | ence 6 to the ow injury occurrent treet and Number | ed | at scene |
| | To the Hospital or within 24 hours after To the Funeral Dircompletely filled in | Medical C | 29a. Certifier (Check only one) 1 Certifyin 2 X Medical (| g Physician: To the besixaminer: On the basis and manner: | st of my knowledge, death of examination and/or inv stated. | occurred at the time restigation, in my op | e, date and place, inion, death occur | and due to the c | ause(s) and mai late and place, a | nner as sta | ited. the cause(s) |
| | To th withir To th comp | Me | 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person of the certifier | One Uhe | LL IUD death (ftem 23a) (Type, | 29c. License O.C.N | | | 29d. Date signed November | | |
| | Sta | _ | 31. Date filed (Month, Day, Year) | A KODE | trar's Signature | 1 Penn St | reet, Ba | altimore | , Maryla | and 21 | 1201 |
| | Registr | ar | NOV 2 8 2005 S. | | | | | | | | |

| | | | For State Registrar | State of Mai | • | partment of | | | | ene 2005 | 38049 |
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| ľ | Physici | an | 1. Decedent's Name (First, Middle, Last) | | | | | 2 | Date of Death | Day Year | 3. Time of Death |
| | /Medic Examir | cal | ARSENA W. PERRY 4a. Facility Name (If not institution, give s DOCTORS HOSPIT | reet and number) | | Lan | | n of Death | | 1 | , ,,,,, |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Funeral Director | | 5. Social Security Number 242-30-0007 Usual Residence of Decedent | | (In yrs. last birthd 35 Yrs | Months D | fear If Under lays Hours | er 24 Hrs. 8 Min. N | Date of Birth (Month, Day, OV • 26 | ,1919 S. | rthplace (State or Foreign ountry) Carolina |
| | Maryland e-fahow | ctor | 10a. State 10b. County | | 10c. City, Town o | Cocation GTON, I | D. C. | | | | 10d. Inside City Limits 1 Yes 2 □ No |
| | 3a or 28 | I Director | 10e. Street and Number 601 EDGEWOOD ST | REET, N | 102 E. APT | | | | 1 | g. Citizen of What C ${\sf J}$. ${\sf S}$. ${\sf A}$. | ountry? |
| 980 | hours after death with the Maryland turel', or Items 23s or 28e-f ahow all Executive frout be retitined at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | er in U.S. | 3. Was Deceden If Yes, specify 1 Yes 2 | | | fy Yes or No- can, etc.) | 14. Race - Am Black, Whi Specify: | |
| 21215-0036 | within 72 ane. than "nai | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | | (G | cedent's Usual C ive kind of work of e. DO NOT use i | tone durina mo | ost of working | | 6b. Kind of Business | |
| Maryland 2 | ould be filed Mental Hygianked other | To Be C | 17. Father's Name (First, Middle, Last) EDDIE A. WILLIA | MS | | | | , | | aiden Sumame) HARRISON | |
| Baltimore, Mary | es 1 and 2 sho of Health and litem 27 Is m r other treum | | 19a. Informant's Name/Relationship (Typ. JAMES EDWARD PEF 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) | RRY | 192 20b. Place of Di cemetery, | | AVE. | CAPIT | OL HE | City or Town, State, IGHTS, M Oc. Location - City of SUITLAND | D. 20743 Town, State |
| Baltir | permit. Page Department Important: It any injury o | | 21. Signature of Funeral Service License | hims | | 22. Name and A | ddress of Fac | lity LAT | NEY'S | FUNERAL | |
| 8760, | Physician /Medical Examiner physician and physician and the prujal-transit | Ical Examiner | 23a. Part1. Entir the "Isease, of complic shock, or leart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. | Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due | consequence of): | | ercil | | espiratory arres | red | Approximate Interval Between Onset and Death |
| .O. Box 68 | death certific e attending p id for use as | hysician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown | ic. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown | Fetal death | 3 Ectopic pregr | | | | 23d. Date of de Month | livery Day Year |
| <u>a</u> | gned be de | by P | Part II. Other significant conditions conf | ributing to death but | not resulting in th | e underlying caus | e given in Parl | t I. | | | o the cause of death? |
| of Vital Records, | The law ate has b page 2 sl | Completed | | | | | | | 24a. Was an autopsy performe 1 ☐ Yes 2∫ | prior to death? | utopsy findings available completion of cause of |
| of Vit | Physician: 1 this certifical al director, p | To Be | T Tes Z No | ospital: 1 / Inpatient | | | Cther: 4 N | Nursing Home | | ce 6 ☐Other (Spe | icify) |
| Division o | tending death. tor: After the funer | Certification; | 27. Manner of Death 1. Natural 2 Accident 3 Suricide 4 Homicide | 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. | - At home, farm, | м | Injury at Work? 1 Yes 2 | □No | | rinjury occurred et and Number or R State) | ural Route Number, |
| D | Hospite 4 hours Funerel tely filled | edical Cer | 29a. Certifier 1 Certifying Physic (Check only one) | cian: To the best of | my knowledge, do | | | | | | |
|) | To the Hos within 24 h To the Fun completely | Med | 29b. Signature and title of certifier | Linfon | phy | | cense number | | | 1. Date signed (Mont | |
| | | | 30. Name and address of person knolcor | | th (Item 23a) (F) | 00, Print) | 773 | y Bel | le Port | 11/2 T D. g. | enlet The |
| Constant of the Constant of th | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2, 8, 20 | 32. Registrar | s Signature | Sperte | | | | U | |

| | | | FOR | artment of Health and Mental Hy | _ |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 100 | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Michele L. Pittman | 2. Date of De Month Novembe | Day Year 22, 2005 10:35 A M |
| * | Examir Funeral Director | ier | 4a. Facifity Name (If not institution, give street and number) Stella Maris 5. Social Security Number 219-30-7390 6. Sex 1 M 2 F 77 Yrs. | 4b. City, Town, or Location of Death Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Bir (Months, Days Hours Min. Jan. 3 | 4c. County of Death Baltimore th (State or Foreign Country) 1, 1928 South Africa |
| | Maryland e-f ehow | ctor | Usuaf Residence of Decedent 10a. State 10b. County 10c. City, Town or Li Maryland Baltimore | ocation Perry Hall | 10d. Inside City Limits 1 ☐ Yes 2X No |
| | within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28e-f ehow ha Madleal Examinar must ba ricilitied at | Funeral Director | 10e. Street and Number 9607 Haven Farm Road Unit H 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? | 10f. Zip Code 2 1 1 2 8 Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. |
| 21215-0036 | 72 hours afte natural', or it ilcal Examin | þ | 3 ☐ Widowed 4 ☼ Divorced Year or Dates: | 1 ☐ Yes 2 🛣 No Specify: adent's Usuaf Occupation a kind of work done during most of working DO NOT use retired) | Specify: White 16b. Kind of Business/Industry |
| | nould be filed within I Mental Hygiene. narked othar than " natic event, tha Ma | Be Completed | 17. Father's Name (First, Middle, Last) | e-taker 18. Mother's Name (First, Middle | |
| Maryland | nd 2 should balth and Mental 27 is marked r traumatic e | Tol | (Names Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mail | (Names Unknown ing Address (Street and Number or Rural Route Numb Churchill Road, Unit G, | er, City or Town, State, Zip Code) |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or itema 23s or 28e-f show any injury or other traumatic event, the Madical Examinat must be rutified at once. | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee | osition (Name of Pate amatory or other place) Crematory 11/23/2005 22. Name and Address of Facility Schimunek | 20c. Location - City or Town, State Baltimore, Maryland Funeral Homes |
| A. | Physician | | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. OVARIAN CANCER resulting in death) | 9705 Belair Rd., Baltimon | |
| 760, 🔅 | Medical Examiner Asicien and e burial-transit | cal Examiner | Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | |
| O. Box 687 | that the death certificate ed by the ettending physi detached for use as the I | Completed by Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown | □Ectopic pregnancy □ Other (specify) | 23d. Date of defivery Month Day Year |
| ords, P.O. | w requires that the been signed by th should be detache | ed by Ph | Part II. Other significant conditions contributing to death but not resulting in the | , , , , , , , , , , , , , , , , , , , , | tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Nunknown |
| Vital Records, | The law ate has b page 2 st | e Complet | | 24a. Was auto pent 1 ☐ Yes 26. Place of Death (Check only | psy prior to completion of cause of death? 2 № No 1 ☐ Yes 2 ☐ No |
| Division of Vit | Ø 5. × | Certification; To Bo | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien | ont 3 DOA Other: 4 Nursing Home 5 Resi of 28c. Injury at Work? M 1 Yes 2 No | idence 6 Nother (Specify) HOSPICE how injury occurred |
| Div | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | edical Certif | | City or To | wn, State) cause(s) and manner as stated. |
| | | Med | 29b. Signature and title of confiler | 29c. License number D43725 | 29d. Date signed (Month, Day, Year) |
| | 10 | ate | 30. Name and address of person who completed cause of death (Item 23a) (Type DR. TARIO MAHMOOD 2300 DULANEY VAL. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature | LEY RD. TIMONIUM, MD 210 | 093 |
| 4 | Regist | | | Gerle) | |

DHMH 17 Rev 1/2001

10:35 а.ш.

NOVEMBER 22, 2005

MICHELE PITTMAN

ORIGINAL

38051

State Registrar

DHMH 17 Rev 1/2001

Towned h

31. Date filed (Month, Day, Year)

EDWARD SCHIEFER

YULICE

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

-MO 11055 LITTLE PARUXSHT

NI

32 Registrar's Signature

George M.

NOV

cocumBiA, MD. 21044

25, 2005

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last, Month Day Year **Physician** Rothrock 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltinore University of maryland medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. November 10,1942 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XX M 2 F California 63 215-42-0048 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itams 23s or 28s-f ehrow eny injury or other traumatic event, the Medical Experiment. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. Count 1 Tes 2/10/No Baltimore Ruxton Directo Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 USA 1917 Ruxton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amped Forces? Varyes 2 □ No Vietnam 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Marned Specify: White 1 □ Yes XX No If Yes, Give Year or Dates: ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Colonel U S Air Force 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Earl Rothrock Sr Mary Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POA/PR 1917 Ruxton Road Ruxton, Maryland 21204 Mary Mueller Greenwood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State 11/28/05 Baltimore, Maryland GreenMount Cemetery □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Service 6500 York Road Baltimore, Maryland 21212 nnes X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Thrombas orting /Medical Due to (or as a consequence of): Examiner 10-1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physicien should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4 ☐Unknown 1 ☐ Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? hes page 2 this certificate some 2□ No 1 ☐ Yes rachno 1 ☐ Yes 2 1 No the Hospitel or Attending Physician; To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 10 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending investigation 2 □ No death. 1 TYes 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4614 n.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) as siereene Williance 31. Date filed (Month, Day, Year) 82. Registrar's Signature State NOV 2 Registrar

| | | | 1- State of Maryland / De State of Maryland / De | epartment of Certificate of | | | ene 005 | 38053 |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death | | 3. Time of Death |
| | Physici /Medio | | Nellie Curry Robertson | | | November | 14, 2005 | 5 1:35 A ^M |
|) | Examir | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, | or Location of D | Death | 4c. County of De | |
| | | | Larkin Chase Nursing Home | Bowie | | | Prince (| George's |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe | Months Days | | Min. (Month, Day, Y | (ear) 9. B | irthplace (State or Foreign Country) |
| | Director | | 251-62-8988 | 3. | | May 23, | 1937 Sοι | th Carolina |
| | yiand yow | | 10a. State 10b. County 10c. City, Town of | or Location | | | | 10d. Inside City Limits |
| | Mar 6-1- | to | MD Prince George's Bowie | | | | | 1 XYes 2 No |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hyglene. This man and Mentall Hyglene. This marked other then "naturel", or iteme 23a or 28e-f ehow any injury or other traumatic event, the Medical Examination and the notified at once. | Funeral Director | 10e. Street and Number 15005 Health Center Drive | 10f. Zip Code 20716 | | 10g | . Citizen of What C | Country? |
| | me 2 | Jera | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. Was Decedent of | Hispanic Origin | ? (Specify Yes or No- uerto Rican, etc.) | 14. Race - Am | nencan Indian. |
| Q | or its | Ē | 1 Never Married 2 Married 1 Yes, Give 1 Yes, Give 1 No | If Yes, specify Cub | | uerto Rican, etc.) | Black, Wh | ite, etc. |
| 8 | irel', | d by | 3 Widowed 4 Divorced Year or Dates: | 1 Yes 2 TNo | Specify: | | Specify:] | Black |
| 21215-0036 | natu | Completed | 15. Decedent's Education (Specify only highest grade completed) (G | ecedent's Usual Occu Give kind of work done fe. DO NOT use retire | pation during most of | working 16 | b. Kind of Busines | s/Industry |
| 2 | withir sne. | E C | | fe. <i>DO NOT</i> use retire Domestic | od) | | Home | |
| 0 0 | Hygie ther ther | ပိ | 17. Father's Name (First, Middle, Last) | | 18 Mother's | Name (First, Middle, Ma. | | |
| Maryland | id be entai ked o | To Be | Clarence Jess Curry | | | la Anderson | iden Sumame) | |
| ary | shound M | - | | lailing Address (Street | t and Number or | r Rural Route Number, C | itv or Town. State. | Zip Code) |
| Ž | and 2 aith a 127 le | | | | | New Carrol | | |
| ore. | of He of He fitam roth | | 20a. Method of Disposition 20b. Place of D 1 △Burial 2 □ Cremation 3 □ Removal from State 7 | isposition (Name of crematory or other pla | ice) | Date 20 | c. Location - City o | r Town, State |
| Ĕ | Pag nent ant: I | | | ew Memory | 0.1 | 1/18/05 | York, S | SC |
| Baltimore, | emit. Separti nport ny nj | | 21. Signatus of Funeral Service Licensee | 22. Name and Addre | | | | |
| _ | 40244 | | mu library | | | ork, SC 2078 | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | e Cond | 10 Vas | Culay Di | Sean | real |
| | Examiner | | Due to Jdr as a consequence of): | 7-6-0 | 0.110 | Cular Di | | |
| | | e | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | D1201 | au | | | y tans |
| | d d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | 21) | | | | LIEGA P |
| ĵ. | en an en an irial-tr | Exa | resulting in death) Last Due to (or as a consequence of): | \$1.3, | | | | Johns |
| 04/8 8/90 | ficate be executed physicien and s the burial-transit | dicai | d | | | | | |
| | e as 1 | Med | IF FEMALE: | | | | | |
| X Q Q | death certiff e ettending od for use as | ician/Me | | 3 Ectopic pregnanc | y | | 23d. Date of de | , |
| j. | e law requires that the death certifi has been signed by the ettending i je 2 should be detached for use as | Physic | 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 9☐ Unknown 9☐ Unknown | 5 ☐ Other (specify) _ | | | Month | Day Year |
| 7. | that the the the the the the the the the th | H. | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause on | en in Part I | 23e Did tobac | CO use contribute t | o the cause of death? |
| Hecords, | The law requires that the same same same same same same by the sage 2 should be detached. | d by | Dementia. | , , | | 1 ☐ Yes | _3 | robably 4 Unknown |
| ဂ လ | w req | lete | | | | 24a. Was an | / | |
| ı L | The la | Completed | | | | autopsy | prior to death? | utopsy findings available completion of cause of |
| Vital | ician: Th certificete rector, pag | ပိ | 25. Was case referred to medical | | 20 Plans -4.5 | performéed 1 ☐ Yes 2 🔀 | No 1 ☐ Yes | 2 □ No |
| 5 : | yelci is cer direc | 0 8 | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa | tient 3 DOA Oth | | Death Check only one grant | S □Other (See | ent d |
| 100 | ng Ph ter th | T :u | 27. Manner of Death 28a. Date of Injury 28b. Time | e of 28c. Injur | | 28d. Describe how in | | спу) |
| | endir aath. or: Af he fur | atic | 2 Accident investigation | | Yes 2 □No | | | |
| DIVISION | ter de irecte | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | street, factory, office | | 28f. Location (Street City or Town, St | t and Number or Ri | ural Route Number, |
| ב כ | pitel o | | X 0 | | | | , | |
| : | to the hospitel or Attending Physician: within 24 hours after death To the Funerel Director. After this certifica completely filled in by the funeral director, to | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de control of the basis of examination and/or and manner stated. | eath occurred at the tir r investigation, in my o | ne, date and pla pinion, death of | ace, and due to the cause courred at the time, date | e(s) and manner as and place, and due | s stated. to the cause(s) |
| : | within To th comp | Me | 29b. Signature and title of certifier | 29c, Licens | e number | 29d. | Date signed (Mont | h, Day, Year) |
| | 4 | | Rakeh anong M | 0 01 | 2010 | 8 1 | 1/14/ | 05 |
| L | | | 30. Name and address of person who completed cause of death (Item 23a) (Type | | | | | - |
| 9 | ` | | Rakesh Arora, MD 14300 Gallant | t Fox Lane | #222 | Bowie, MD 20 |)715 | |
| | Stat Registra | | 31. Date filed (Month, Day, Year) Registrar's Signature | and a | | | | |

All Copies Are Legible. Mental Hygiene

| 07-01093 | tiease Type of Filling Black Indeligie luk. Fusure Al |
|------------------------|----------------------------------------------------------------------------------------------------|
| Brandon Anthony Raiber | Unpend item#23a.PII.27.28a-f.penME.GS1.1-5-06 TI State of Maryland / Department of Health and N |
| 1 - State Registrar | Certificate of Death |

| | | | 1 - State Registrar | | | Cert | ificate of L | Death | , | Reg. No. | CUU | 38054 |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------|----------------------------|-------------------------------------|-------------------------------------------|-------------------------------------------|---------------|------------------------------|----------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, Last |) | | | | | 2. Date of Dea | ath | | 3. Time of Death |
| | Physicia /Medic | | Brandon Anthon | y Raiber | : | | | | Novembe Novembe | pr 23 | , 2005 | 01:22 A M |
| | Examin | | 4a. Facility Name (If not institution, give | street and number) | | | 4b. City, Town, or | Location of Death | | | County of Death | |
| | | | Mile Post 85.3 AMI | RAK | | | Essex | | | Ва | ltimore | 1 |
| | Funeral Director | | 216-17-8145 | x 7. Aga M 2□F | e (In yrs. last bir 31 | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day 08/12/ | h v, Year) | 9. Birth | place (State or Foreign intry) FL |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tow | n or Loca | ition | | | | | 10d. Inside City Limits |
| | f ehe | ŏ | MD Anne Ar | undel | Pasa | | | | | | | 1 Tes 2 No |
| | the 28a- | Director | 10e. Street and Number | unucı | 1 450 | | 10f. Zip Code | | | 10a Citiza | en of What Cou | .W. |
| | Sa or | Ī | 258 Inlet Driv | Δ. | | | 21122 |) | | | S.A. | |
| | ms 2 | Funerai | 11. Marital Status | 12. Was Decedent I | Ever in U.S. | 13. W | | spanic Origin? (Spe n, Mexican, Puerto | ocify Yes or No- | | 4. Race - Amer | ican Indian, |
| 21215-0036 | be filed within 72 hours after death with the Maryland nta! Hygiene. ed other than "natural", or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at event, | þ | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates: | No | | es, specify Cubar | Specify: | Rican, etc.) | | Black, White Specify: Whi | |
| 20 | 72 ho | Completed | 15. Decedent's Edu (Specify only highest grad | cation | 16a. | Decede | nt's Usual Occupa | ition | 20 | 16b. Kind | d of Business/Ir | |
| 21 | within and the series of the s | npie | Elementary/Secondary (0-12) | College (1-4or 5 | +) | life. Do | NOT use retired) | uring most of worki | ng | | | |
| 21 | filed wi Hygien sther th | Cou | 10 | | | Car | pet Ins | | | | peting | 1 |
| Maryland | tal H d oth | Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Name | | | | |
| yla | ages 1 and 2 should b int of Health and Ment t: If Item 27 is marked y or other traumatic e | ٩ | Thomas Frank R | | | | | Sandra | | | | |
| Mar | l 2 sh and r | y I | 19a. Informant's Name/Relationship (T) | | 1 | | | nd Number or Rura | | | | |
| | l and lealth im 27 | 1 | Sandra L. Conne | r / Moth | 20b. Place of | | | cive, Pa | | | | |
| Ö | Pages nent of H ant: If Its ary or of | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F | | cemeter | ry, crema | tory or other place |) | ate | | ation - City or T | |
| ij. | tmer tent: | | 4 □ Donation 5 □ Other (Specify) | | Bayvi | Lew | Cremato | ory 11/2 | 26/05 | Bal | timore | , MD |
| Baltimore, | permit. Page Department of Important: If any injury or once. | | 21. Signature of Furieral Service Licens | 99 | | | | | | | | Home, PA |
| | 20200 | | 222 Part Francisco | inations Mast annual | About Day | | | era Driv | | | na, ML | |
| | Physician /Medical | | 23a. Part1. Enter the disease, or complete shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) | Multiple | | | the mode of dying | , such as cardiac o | r respiratory ari | rest, | | Approximate Interval Between Onset and Death |
| | Examiner | | Sequentially list conditions. | 0, | | | | | | | | |
| | D # | iner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying | Due to (or as | a consequence | ofje | | | | | | |
| | and I-tran | Exam | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequence | of): | | | | | - | |
| 68760, | ertificate be execul fing physicien and e as the burial-tran | | | 000 10 (01 23 1 | a consequence (| 01). | | | | | | |
| 387 | phys the | Medical | | d | | | | | | | | - Seatter |
| O. Box (| death c e attanc | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal death | | ctopic pregnancy Other (specify) | | | 23 | d. Date of deliv Month | ery Day Year |
| Δ. | that the led by th detache | | Part II. Other significant conditions con | ntributing to death bu | at not resulting in | n the und | erlying cause give | n in Part I. | 23e. Did to | bacco use | contribute to t | he cause of death? |
| ds. | uires n sign | d by | Cocaine Intoxication | | | | | | 1 🗆 Y | es 2 🗆 | No 3∏Prot | pably 4 □Unknown |
| Vital Records, | The law requires ate hes been sign bage 2 should be | Completed | | | | | | | 24a. Was a | ın . | 24h Were auto | posy findings available |
| Re | The lav | m d | | | | | | | autops | sy | death? | opsy findings available impletion of cause of |
| <u>la</u> | 77 - 1 | ပိ | 25. Was case referred to medical | | | | | 00 81(8 | | 2 🗆 No | 1 Yes | 2□ No |
| 5 | Physician: r this cartific ral director, | To B | examiner? | lospital: | nt 2□ER/Ou | toationt | Othor | 26. Place of Death | | 100 | 70**** (2 | |
| ō | ding Physician: h. After this cartific tuneral director, | | 27. Manner of Death | 28a. Date of Injur | | Time of | 28c. Injury Work | 4 Nursing Hon | 8d. Describe h | | | |
| Division | Attending r death. ector: After by the fune | atio | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation | 11/23/2005 | | | | es 2 X No | | | | |
| <u>S</u> | or Attendation of Director: | Hick | 3 Suicide 6 Could not be determined | 28e. Place of Inju | ry - At home, fa | | t, factory, office | 2 | 28f. Location (Si | treet and I | Number or Aura | al Route Number, |
| ā | al or | Certification: | 4 Diriomolds | Found: ne | | ad tr | acks | | _ | | | 85.3 AMIRAK |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | Medical (| 29a. Certifier (Check only one) 1 Certifying Physical Cardinal Control Contro | sician: To the best of | of my knowledge examination and | , death o | ccurred at the time | e, date and place, a | ind due to the care at the time, d | ause(s) ar | nd manner as s | tated. the cause(s) |
| | To the within 2 To the complet | Ž | 29b. Signature and title of certifier | | 1 . | | 29c. License | number | 2 | 9d. Date s | signed (Month, | Day, Year) |
|) | | " Patrilled Alex | | | | 0.C.M.E. November 23, 2005 | | | | 2005 | | |
| IN | 7 | | 30. Name and address of person who co | | eath (Item 23a) (| Туре, Рг | | | TAG | 2 A CTIID | ~1 4J, | 400) |
| 110 | | | ARILICEIA | H // | 111 Do | nn (| troot B | 21 timoro | Mo 2027 7 | - L | 1201 | |

State Registrar



Louis Walter Reed, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-07863 State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistra Reg. No. 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JR. WALTER REED, November 21, 2005 10:23 P M LOUIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore 4209 Morrison Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 10 M 2□F Months Days Hours 217-50-8039 Usual Residence of Decedent COTOBER 27, 1948 MARYLAND Director 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State Worle ir then "natural", or itema 23a or 28a-f ehov the Madical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 ARROLL ST. 2611 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 ☐ No 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 ☐ Widowed 4 1 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other then HOME IMPROVEMENTS CARPENTER 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be REED SR. JANE HERZBERGER LOUIS WALTER MARY ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 is Department of Heelth ar Important: if item 27 is eny injury or other trau once. BALTO. MD. 21228 106 GLENWOOD AVE SON MICHAEL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State BAYVIEW CREMATORY 10-23-05 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GONCE FUNERAL SERVICE P.A. 21. Signature of Funeral Service Licenses BALTO 4001 RITCHIE HWY MD raminouski 23a. Part1. Enter the disease to complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) & KYPERTENSIVE AMEROSCIEROTIC CARDIOWASONAR /Medical Due to (or as a consequence of) DISEASE Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician efor use as the burial Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMANOLISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC 24b. Were autopsy findings available prior to completion of cause of death?

1. ∴Yes 2 □ No 24a. Was an 1 XYes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2 No ٩ : After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending 1 Naturat 1 ☐ Yes 2 ☐ No investigation death. 2 Accident i Director: / 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 22, 2005 O.C.M.E.

State Registrar

ANA 31. Date filed (Month, Day, Year) NOV 2 8 2005

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO, MD

111 Penn Street, Baltimore, Maryland 21201

| Physic | | 1- For Unpend Item 23a,27,28a- 1. Decedent's Name (First, Middle, Last) Jeannette M. Ros | senstein | | | 2. Date of Death Month NOVEMBER | | 3. Time of Death |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------|
| /Medi Exami | | 4a. Facility Name (If not institution, give street and number) | EUSTETII | 4b. City, Town, or L | ocation of Death | NOAEMBEK | 4c. County of De | |
| _ > : * | - | 6854 SANCTURY COURT | | ELKRIDGE | | | HOWARD | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age 133-50-5974 1 M 2 F | 37 Yrs. | If Under 1 Year Months Days | Hours Min. | 8. Date of Birth (Month, Day, Ye March 10, | 9. B | Birthptace (State or Forei Country) VEW York |
| death with the Maryland ms 23e or 28e f ehow | _ | | 10c. City, Town or Loc | | | | | 10d. Inside City Limit |
| the Mi | Director | 10e. Street and Number | Elkri | 10f. Zip Code | | 100 | . Citizen of What (| 1 ☐ Yes 2 🛣 N |
| ath with | rai Di | 6854 Sanctuary Court | | 21075 | | 103. | U.S.A. | Soundy? |
| ours after der rat', or items Exeminer n | by Funerai | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: | lo If | Vas Decedent of Hist f Yes, specify Cuban, I ☐ Yes 2 🛛 No | , Mexican, Puerto I | ecify Yes or No- Rican, etc.) | 14. Race - An Black, Wh Specify: | |
| iges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+ | (Give k | lent's Usual Occupati kind of work done du DO NOT use retired) ICher | ion ring most of workin | ng 16b | b. Kind of Busines | • |
| should be filed nd Mental Hyg marked other imatic event, I | To Be C | 17. Father's Name (First, Middle, Last) Brendan McNama: | ıra | 1 | 8. Mother's Name | (First, Middle, Maid | | |
| nd 2 shou alth and M 27 le mar r traumat | - | 19a. Informant's Name/Relationship (Type, Print) David Rosenstein-husband | 19b. Mailing 4273 | g Address (Street and Bright Ba | d Number or Rura av Way, F | /Route Number, Ci | ity or Town, State, | , Zip Code) 21042 |
| permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other trau ance. | | 20a. Method of Disposition 1 ※ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. Place of Dispos | sition (Name of place) | D | ate 20c | c. Location - City o | or Town, State |
| Departm Departm Imports any inju | | 21. Signature of Funeral Service Unisee William (| G. Dau 22. | | of Facility Ruck | k Towson I | | Home, Inc. |
| Physician /Medical Examiner (the prijal-transit | dical Examiner | Sequentially list conditions, france land cause. Enter Underlying Cause (Disease or injury that initiated events c. | ne Intoxica consequence of): | | SUUI da valgració. | respiratory arrest, | | Approximate Interval Bete Interval Bete Interval Between Onset and Death |
| t the death certifi by the attending ached for use as | hysician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9☐ Unknown | Fetal death 3 E | Ectopic pregnancy Other (specify) | | | 23d. Date of de Month | elivery Day Year |
| w requires tha been signed I should be det | b | Part II. Other significant conditions contributing to death but r | not resulting in the und | derlying cause given i | in Part I. | 23e. Did tobacc | | to the cause of death? Probably 4 Unknov |
| in: The law ri ificete has be or, page 2 sh | Completed | 25. Was case referred to medical | | | | 24a. Was an autopsy performed? | ? qeath? | nutopsy findings availab completion of cause of s 2 \(\sum \text{No} \) |
| ding Physician: n. After this certific funeral director, | To Be | examiner? 1 XYes 2 No Hospital: 1 Inpatient | t 2 ER/Outpatient | 04 | 6. Place of Death 4 ☐ Nursing Hom | (Check only one) ne 5 ☐ Residence | 6 TXOther (Sp. | ecity) SCENE |
| r Attending Ph er death. rector: After th by the funeral | Certification; | 27. Manner of Death 1 Natural 2 Accident investigation 37 Suicide determined 6 Could not be determined 28a. Date of Injury 1 - 18 - 09 Y 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury building, etc. (| y - At home, farm, stree | 28c. Injury at Work? M 1 ☐ Yes | 28 s 2 X No | 8d. Describe how in Subject in 8f Location (Street | ngested | drug |
| To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr | 1 | 29a. Certifier (Check only (2 Medical Examiner: On the basis of ex | my knowledge, death o | Occurred at the time | date and place an | d due to the | riatytan | |
| To the twithin 2. To the complete | 2 | 29b. Signature and title of certifier 30. Name and address of person who completed cause of deat | 1 | 29c. License nu | umber | 29d. C | Date signed (Moni | th, Day, Year) |
| | | JA(K M. Tith, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's | | 111 PENN | STREET B. | ALTIMORE, | MARYLAND | 21201 |

| | | - | For State Registrar | State of Mar | yland / De <i>C</i> | partmer e <i>rtificat</i> | t of H e of L | ealth a Death | and M | lental Hy | giene Reg. No | | 38057 |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------|-------------------------------------------|--------------------------|----------------------------|-------------------------|----------------------------------------------|------------------|-----------------------------------|----------------------------------------------------|
| 100 | ÷ | Å. | 1. Decedent's Name (First, Middle, Las |) | | | | | | 2. Date of De | eath Da | y Year | 3. Time of Death |
| 100 | Physicia /Medic | 4.3 | BEATRICE | М. | RE | ICHLYN | | | | NOVEMBI | | 1 2005 | 8:00P M |
| | Examin | · · · · · · · · · · · · · · · · · · · | 4a. Facility Name (If not institution, give | | | 4b. City, | Town, or | Location | | CTOUN | 40 | . County of Death | |
| | © ≱. y. | | FUTURE CARE CHE 5. Social Security Number 6. Se | | (In yrs. last birthda | (V) If Under | 1 Year | KE I | | STOWN 8. Date of Bir | rth | | TIMORE |
| . * | Funeral Director | | | M 2√ F 9 | | Months | | Hours | Min. | 07/24/ | 1913 | Coi | MD |
| | 146.1 | | Usual Residence of Decedent | | | | | | | | | | |
| | arylan show | _ | 10a. State 10b. County | | 10c. City, Town or | | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2☐ No |
| | the Mi | Director | MD BALTIMOR 10e. Street and Number | Ł | OWINGS | MILLS 10f. Zip | Codo | | | | 10a C | tizen of What Co | |
| | ath with the Maryla 23s or 28s-f shor ust be notified at | | 8 BRIDLEWOOD CO | IIDT | | | 117 | | | | iog. O | U.S.A. | • |
| | death | Funerai | 11. Marital Status | 12. Was Decedent Ev | er in U.S. 1 | | | ispanic Or | igin? (Spe | ecify Yes or No Rican, etc.) | o- | 14. Race - Amer | ncan Indian, |
| 936 | filed within 72 hours after death with the Maryland Hygione. Hygiona then "netural", or Items 23s or 28s-f show ent, the Medical Evantral must be notified at | by Fur | 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 | | 1 Yes, spe | | Specify: | | Hican, etc.) | | Black, White Specify: W | HITE |
| 2-0 | 72 ho | ted | 15. Decedent's Ed (Specify only highest grad | ucation | 16a. De | cedent's Usu | al Occupa | ation | st of works | ina | | (ind of Business/ | |
| 21 | ithin 19. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) |) ! | ve kind of wo | | | | 9 | | S. VETER INISTRAT | |
| 121 | e filed with I Hygiene. other than | | 17. Father's Name (First, Middle, Last) | 2 | DEB | T COLL | ECT0 | | or'n Nome | (First, Middle | 1 | | TON |
| ⊑ | be at a p | To Be | SAMUEL | | REICH | | | NE7 | TTIE | | | | BUD0FF |
| Mar | d 2 st th and 7 Is m treum | | 19a. Informant's Name/Relationship (7 | | | | | | | | | or Town, State, Z S, MD 21 | |
| | s 1 and 2 should f Health and Mer item 27 is marke other treumatic | 1 % | 20a. Method of Disposition | / NILOL | 20b. Place of Dis | position (Na | me of | 1 | | Date | - | ocation - City or | |
| <u> </u> | Pages nent of nt: If it iry or o | | 1 Burial 2 Cremation 3 C | | WORKMEN | rematory or o | • | , 1 | L1-/22 | /2005 | RΛI | TIMORE, | MD |
| | 그 는 은 근 | | 21. Signature of Funeral Service Licen | | WORNIEN | 22. Name a | | | ity | North College College | 117 | | |
| ä | Depa Depa Impo any it | | 1/2/4 | | 1.5 | 8900 | PEIS | TERSI | | | | & BROS. ESVILLE, | |
| | Physician /Medical Examiner | | 23a. Part1. Enter the sease, of compshock, or heart ailure. List only of immediate Caus Final disease or condition resulting in death) | a Alz | consequence of): | enter the mod | de of dyin | g, such as | cardiac d | or respiratory a | irrest, | | Approximate Interval Between Onset and Death |
| 8760, | cate be executed chysician and the burial-transit | dical Examiner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | consequence of): | | | | | | | | |
| P.O. Box 68 | To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 1 | 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown | ☐ Fetal death | 3 ⊟Ectopic p 5 ⊡ Other (s _i | | | | | | 23d. Date of deli Month | very Day Year |
| σ. | res that igned b be deta | by Pi | Part II. Other significant conditions or | ntributing to death but | not resulting in the | underlying | cause giv | en in Part I | l. | 23e. Did | tobacco | use contribute to | the cause of death? |
| rds | w requires been sign should be | | | | | | | | | 1 🗆 | Yes 2 | 3 □ Pro | obably 4 Unknown |
| Vital Records, | The law requ te has been age 2 shou⊦ | Completed | | | | | | | | 24a. Was auto perfe 1 \(\sum \) Yes | | prior to death? | topsy findings available completion of cause of |
| ital | icien: The certificate h rector, page | BeC | 25. Was case referred to medical examiner? | | | | | 26. Place | e of Death | (Check only | | - | |
| of V | hysic this ce al direc | 2 | 1 ☐ Yes 2 → No | Hospital: 1 Inpatient | 2 ER/Outpa | tient 3 D | Oth Oth | er: | ursing Ho | me 5□Res | idence | 6 ☐Other (Spec | city) |
| ion o | inding Ph ath. ir: After th | ation: | 27. Manner of Death 12. Natural 5 Pending 2 Accident investigation | | Year) 28b. Time Injur | | 28c. Injun Worl | ∤at k? Yes 2⊡ | | 28d. Describe | how inju | iry occurred | |
| Division | To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fur | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injur building, etc. | y - At home, farm, (Specify) | street, factor | y, office | | | 28f. Location (City or To | | | ral Route Number, |
| | he Hospi n 24 hour he Funer bletely fill | Medical | 29a. Certifier (Check only one) 2 Medical Exam | ysician: To the best of iner: On the basis of e and manner state | examination and/o | eath occurred r investigation | at the tin n, in my o | ne, date ar pinion, dea | nd place, ath occurr | and due to the ed at the time, | cause(s | and manner as d place, and due | stated. to the cause(s) |
| | To the To the Comp | Σ | 29b. Signature and title of certifier | ~ | | | | e number | | | 29d. D | ate signed (Month | n, Day, Year) |
| | | | 1 Thanse | | | 1 | 25 | 112 | | | 11/ | 22/20 | 0 8 |
| | | } | 30. Name and address of person who | | | oe, Print) | od. | o Dr | - 5 | wite ! | 01 | 100: | 117 |
| | Ç. | | 31. Date filed (Month, Day, Year) | J2 Registrar | | | 04 | SHO | 35_ | rull |) [| I D dl | 11 / |
| | Sta Registi | | 110U 9 o 20 | 25 | An A | matel 1 | | (| U | | | | |

Amedn item#20a-c, 22, perFH G849 11/29/05 TT
State of Maryland / Department of Health and Mental Hygiene

| | | | | Olu | | ar y laria r | • | tificate of | Death | • | Reg. No. | 15 | 38058 |
|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|-------------------|----------------------------|---------------------|----------------------------------------|-----------------------------------------|---------------------------------------------|------------------------------|-------------------|------------------|----------------------------------------------------|
| | | | 1. Decedent's Name (First, Mid | dle, Last) | | | | | | 2. Date of De | ath | | 3. Time of Death |
| н | Physici /Medio | | Alfred Shor | t | | | | | | Month Novemb | er 10, 2 | Year 2005 | 9:45 AM |
| - | Examir | | 4a Facility Name (If not instituti | on, give street a | nd number, |) | | | 4b. City, Town, or Lo | | | | 1 7 1 3 2 m 1 |
| 7 | | | Larkin Chas | e Nursir | ng Cer | nter | | | Bowie | | Princ | e Ge | orge's |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. A | ge (In yrs. last b | irthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | | | place (State or Foreign |
| | Director | | 239-48-5844 Usual Residence of Decedent | 1 M 2 € | □ F | 73 | Yrs. | Months Days | Hours Will. | Apr 18, | 1932 | | "" unk |
| | and w | | 10a. State 10b. Count | у | | 10c. City, To | wn or Loc | ation | | | | 1 | 10d. Inside City Limits |
| | Aaryl sho | ō | | e Georg | e1e | | Bowi | | | | | | 1 ☐ Yes 2 ☐ No |
| | the the | ect | 10e. Street and Number | | | | DOWI | 10f. Zip Code | | | 10g. Citizen of V | What Cour | 21 |
| | with po o | Funeral Director | | | _ | | | Toil Zip Godo | | | rog. Onizon or v | mat oou | |
| | aath mes 23 | era | 15005 Health | | | Ever in U,S. | 12 V | Vas Decedent of F | 20716 | ecity Ves or No | US 14 Bac | SA e - Americ | can Indian, |
| _ | iter d | ş | 1 □ Never Married 2 □ Ma | Arm | ed Forces | ? | if. | Yes, specify Cub | lispanic Origin? (Sp an, Mexican, Puerto | Rican, etc.) | Blac | k, White, | |
| 20 | irs af | | 3 ☐ Widowed 4 🏋 Divorce | lf V | es, Give | 110 | 1 | ☐ Yes 21 No | Specify: | | Specify | bla | ick |
| Baltimore, Maryland 21215-0020 | parmit. Pages 1 and 2 should be filad within 72 hours aftar daath with the Maryland Dapartment of Health and Mental Hygiena. Important: if item 27 is merked other than "natural", or items 23e or 28a-f show any follury or other treumatic event, the Medical Examiner must be natified at once. | Completed by | 15. Decede (Specify only high | nt's Education | lotod) | 16 | a. Deced | ent's Usual Occup | pation | ring | 16b. Kind of Bu | ısiness/în | dustry |
| 7 | an a | nple | Elementary/Secondary (0-12) | | ege (1-4or | 5+) | life. D | O NOT use retire | during most of work d) | "'g | | | |
| 7 | ad wi | Ö | 6 | | 0 | | tru | ck drive | | | trans | | tion |
| nd | al Hy al Hy oth | Be (| 17. Father's Name (First, Middle | , Last) | | | | | 18. Mother's Nam | e (First, Middle, | Maiden Sumam | e) | |
| <u>la</u> | Vent Vent rrked rrked | 2 | Alfred Short | Sr | | | | | Sall | ie Vinc | e | | |
| ar | and 2 should be filed within eath and Mental Hygiena. n 27 is merked other than ", her treumatic event, the Mec | | 19a. Informant's Name/Relation | iship (Туре, Prin | nt) | 19 | b. Mailin | g Address (Street | and Number or Run | a <i>l Route Numb</i> | er, City or Town, | State, Zip | Code) |
| ≥. | 1 and 2 Health em 27 i | | Ellen Ringeis | en/execu | itor |] | 301 | Wemley I | Orive Uppe | er Marl | boro, MD | 20 | 772 |
| ore | of He | | 20a. Method of Disposition | 3 Deamous | from State | 20b. Place cemet | of Dispos e <i>ry,</i> c <i>rem</i> | sition (Name of atory or other pla | ce) | Date | 20c. Location - | City or To | own, State |
| Ĕ | Pages nent of B int: if ite iry or of | | 4 Donation 5 NOther (| Specify) in | state | | inco | 1n Cemet | ery 1 | 1/25/0 | Brent | wood | , MD |
| alt | parmit. Page Dapartment of Important: if any injury or once. | | 21. Signature of Funeral Service Ronald | | | | 22. | Name and Addre | ss of Facility Ft. | Lincoln | Funeral H | ome : | 401 Bladensbur Street |
| Щ | 8 5 E 8 9 | | Venno 1 | 111 | 1/100 | 7 | Ba | ltimore, | MD 2120 | 122°° W | Daitin | JIC C | treet- |
| ĸ. | P | Г | 23a. Party Enter the disease, shock or heart failure. List | complications | that cause | d the death. Do | | | | | rrest, | | Approximate |
| * | Physician | | shock of heart failure. Us | st only one caus | e on each i | ine. | | | | | | 1 | Approximate Interval Between Onset and Death |
|) | /Medical | | Immediate Cause (Final disease or condition | ∇t | hings | clero | tic | Cenelon | o Vascu | elas- | Distan | 1 | Jeans |
| * | Examiner | | resulting in death) | a. /\ | | Due to (or as a | consequ | uence of): | | | V (30. | | 1 (00 - 3 |
| | D == | ner | | T | PM | ron+ | 101 | | | | | | LIPPINS |
| | rtificata be executad ng physician and s as the burial-transit | Examiner | Sequentially list conditions, | 0. | | Due to (or as a | consequ | uence of): | | | | | J. 1000, |
| 68760, | e exe ian a urial- | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | J | | | | | | | | 1 | |
| 876 | ata b hysic the b | Medical | that initiated events resulting in death) Last | · · · | | Due to (or as a | consequ | ence of): | | | | | |
| <u> </u> | ing p e as | | | | | | | | | | | [| |
| Вох | aath ce attendii I for use | Physician/ | | _ | | | | | | | | | |
| o <u>i</u> | nt tha da by tha s stachad | ysic | Part II. Other significant condit | ions contributing | g to death b | out not resulting | in the un | derlying cause giv | en in Part I. | 23b. Did | tobacco use cor | tribute to | the cause of death? |
| Δ. | Tha law requiras that tha death certificata be executed ate has been signed by the attending physician and paga 2 should be detached for use as the burial-transit | | | | | | | | | 10 | Yes 2 No | 3 Prol | bably 4 ☐ Unknown |
| Division of Vital Records, | uiras 1 sign IId be | d by | | | | | | | | 24a. Was | an autopsy | 24b. W | ere autopsy findings |
| Ö | v require been si should l | lete | | | | | | | | | rmed? | ava | ailable prior to mpletion of cause |
| æ | has ga 2 | Completed | | | | | | | | | 1 | | death? |
| ल | | | 05.34 | | | | | | | 10, | / - | 1 L | ☐Yes 2☐ No |
| ⋚ | car | o Be | 25. Was case referred to medic examiner? | Hospital: | | | | Oth | 26. Place of Death | | | | |
| ō | Phys | - | 1 Yes 2 No 27. Manper of Death | 28a. | 1 ☐ Inpati | | Time of | 3LI DOA | 4 Aursing Ho | | dence 6 Other | | y) |
| 9 | Attending ir death. ector: After by tha fune | for | 1 Natural 5 □ Pend | ing tigation | Date of Inju (Month, Da | ıy Year) | Injury | 28c. Injur Wor M 1 🗆 | rk? Yes 2□No | | ,, | | |
| <u>.s</u> | deat deat ctor: y tha | fica | 3 Suicide 6 Could | not be | Place of In | iurv - At home. f | arm. stre | et, factory, office | | 28f. Location (| Street and Number | er or Rura | I Route Number. |
| 줊 | al or Attending Phy saftar death. I Director: After this d in by tha funeral c | Certification: | 4 ☐ Homicide | mined 288. | building, el | c. (Specify) | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or Tov | vn, State) | | |
| _ | To the Hospital or A within 24 hours aftar To the Funeral Dire complataly fillad in b | | 29a. Certifier Certify | ng Physician: 1 | To the best | of my knowledg | e, death | occurred at the tir | me, date and place, | and due to the | cause(s) and ma | nner as s' | tated. |
| | e Ho Fur lataly | edlcai | (Check only 2 Medica one) | Examiner: On | the basis of manner st | f examination a | nd/or inve | estigation, in my o | pinion, death occurr | ed at the time, | date and place, a | ind due to | the cause(s) |
| | within 2 To the compla | Me | 29b. Signature and title of certifi | er | | | | 29c. Licens | e number | | 29d. Date signed | (Month, | Pay, Year) |
| | | | JARA KI | Sho | 2/11 | na. | MA | Da | 2010 | 8 | 11/1 | 51 | 05 |
| | () | | 30. Name and address of person | 1 who completed | cause of | death (Item 23a) | (Type. F | | | | | | |
| 1 |)/ | | RAKERMA | TROP | AMD | 1430 | 0 | MALL | ANTA | XLN#. | 22L BOY | VIE | 4020715 |
| Ì | Sta | te | 31. Date filed (Month, Day, Yea |) | 32. Registi | rar's Signature | 0 4 | Lanks B | | | | | |
| | Registr | | NOV 2 | 8 2005 | | rar's Signature | P | Tares. | | | | | |

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U () Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day Month 4:20P M **Physician** Kemp Lee Edgar Smith, Sr. Nov.21 2005 /Medical 4a. Facility Name (If not institution, give street and number) #708 4b. City. Town, or Location of Death 4c. County of Death Examiner 201 N. Washington Street N/A Baltimore | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year Dec. 15, 1 5. Social Security Number 6 Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** X M 2 F ,1928N.Carolina Dec. 238-36-3905 Yre 76 **Director** Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County r than "natural", or Items 23a or 28a-f show If e Medical Exerciner must be notified at N/ABaltimore Yes 2 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 201 N. Washington Street #708 10f. Zip Code 21231 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. International it is marked other than "natural, or the Important: If item 27 is marked other than "natural, or the any injury or other traumatic event, the Maxical Examina and easy. NEYes 2 No WW2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XIXNo Specify: Specify:Black ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Company 7th grade Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pearl Taylor Alonia Mack Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 r 3730 Columbus Drive Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Maxine Garland-Bey Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1/05 1 Burial 2 Cremation 3 Removal from State Vet. Cem. Owings Mills, Md 4 □ Donation 5 □ Other (Specify) Garrison Forest Ineral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 ave Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Pnysician disease or condition resulting in death) Non-small cell lung cancer with /Medical Due to (or as a consequence of) Examiner metastases to Liver and Bone yr Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ng physician and as the burial-transit Hypertension yrs The law requires that the death certificate be exect Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Diabetes Mellitus yrs attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 17 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes XXNo or Attending Physicien: ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home XXResidence 6 Other (Specify) 2 2 XNo 1 Tes this 28a. Date of Injury (Month, Day Year) Director: After the 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: **X**□Natural 5 Pending 1 Tyes 2 No death. investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a
To the Funeral C the Hospital XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier D54749 11 25 2005 30. Name and address of person who completed cause of death (16m 23a) (Type, Print) MD 801 Toll House Road Allen Reilly, Baltimore, Maryland 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 8 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

| | | | For State Registrar | State of Maryla | | artment of rtificate o | | nd Mental H | ygiene | 5 380 | 61 |
|-------------------------------------|--------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------|--------------------------------------|------------------------------------|----------------------------------------------|------------------------------------------------|---------------------------------------------|---------------|
| € | 3 | | Decedent's Name (First, Middle, La | ist) | | | | 2. Date of D | Death | 3. Time of | f Death |
| | Physici Medic | J 8 | Florence Irene | Sacker | | | | 11/2 | 5/2005 | 5:43 | АМ |
| <i>i</i> | Examin | | 4a. Facility Name (If not institution, gir | ve street and number) | | 4b. City, Town | , or Location of | | | y of Death | |
| | ě Pos | | Anne Arundel N | | | Annap | | | | Arundel | |
| | uneral | 112 | | 1 CM 2001 F | rs. last birthday, Yrs. | If Under 1 Year Months Day | | Min. 8. Date of E | lirth Day, Year) 1926 | Birthplace (State of Country) | or Foreign |
| | irector | | 216-20-4643 Usual Residence of Decedent | 79 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 10/23 | /1926 | MD | |
| yland | MOL | | 10a. State 10b. County | 10c. | City, Town or L | ocation | | | | 10d. Inside C | ity Limits |
| Mag | e-f-e | ctor | MD Anne A | Arundel F | Pasade | na | | | | 1 ☐ Yes | 2 X No |
| ith the | or 28 | J'e | 10e. Street and Number | | | 10f. Zip Code | Э | | 10g. Citizen of | What Country? | |
| death with the Maryland | 23a | Funeral Director | 9180 Rolling N | 7 | | 2112 | | | U.S.A | | |
| er de | Items Court | nue | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U.S. 13. | Was Decedent o If Yes, specify Co | if Hispanic Orig uban, Mexican, | in? (Specify Yes or N Puerto Rican, etc.) | No- 14. Ra Bla | ce - American Indian, ack, White, etc. | |
| rs aft | i', or | by | 1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: | | 1 ☐ Yes 21 N | lo Specify: | | Speci | White | |
| 3-0030 | "natural", or items 23a or 28e-f ehow edicul Ezer, from must be redified at | | 15. Decedent's E | ducation | 16a. Dece | dent's Usual Occ | cupation | | 16b. Kind of E | Business/Industry | |
| thin 7 | Wed. | Completed | (Specify only highest gi | College (1-4or 5+) | | kind of work dor DO NOT use reti | | of working | | | |
| filed within Hvaiene. | other than "vent, It a Mu | Co | 12 | | Но | rticult | | | Nurse | | |
| 9 8 | od other than | Be | 17. Father's Name (First, Middle, Las | | | | | 's Name (First, Midd | | me) | |
| should Men | marked matic ev | P L | Theodore Frank 19a. Informant's Name/Relationship | | | | | stasia K | | | |
| ~ ~ ~ | - 3 - 3 | | David Sacker | | | | | r o <i>r Rural Route N</i> um adow Run | | 2 | 1122 |
| Te, F | item 27 other tr | | 20a. Method of Disposition | 20b | . Place of Disp | osition (Name of | | Date Date | 1 | - City or Town, State | • |
| Peges Pent of | ry or | | 1 Burial 2 Cremation 3 (4 Donation 5 Other (Spec | Removal from State | - | matory`or other p Hrt. of | | 11/30/05 | Baltin | more. MD | |
| rmit. Peges | Important: If its any injury or o | | 21. Signature of Funeral Service Lice | | | | | | | eral Home | , PA |
| <u>n</u> 88 | E = 8 | | Malla | | | | | | | , MD 2112 | |
| | | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | nplications that caused the de y one cause on each line. | eath. Do not en | ter the mode of d | tying, such as o | cardiac or respiratory | arrest, | Approximat Interval Bet | tween |
| 42.6 | sician | | Immediate Cause (Final disease or condition | - Assication | - nn | eumenis | | | | Onset and | Death |
| | edical miner | | resulting in death) | Due to (or as a cons | | 1 | 1 - | 0 | 1 01 | i | |
| | | <u>~</u> | Sequentially list conditions, if any, leading to immediate | b. De to (or as a cons | News | niswim | - disc | rden (hr | ik, 2 tio | logy | |
| nted | ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | |
| oU, be executed | an and rial-tra | | resulting in death) Last | Due to (or as a cons | equence of): | | | | | | |
| ate be e | hysicien and the burial-transit | cal | | d | | | | | | | |
| Certificate | been signed by the attending pt should be detached for use as t | Physician/Med | IF FEMALE: | | | | | | | | |
| death o | attend for us | lan/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of preg 1☐Live birth 2☐Fe | etal death 3 | Ectopic pregnar | | | | ate of delivery onth Day ' | Year |
| . e | the s | yslc | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□ Pregnant at time o 9□ Unknown | of death 5 | Other (specify) | | | | | |
| ecords, F.O. | deta | P. | Part II. Other significant conditions | contributing to death but not r | resulting in the (| inderlying cause | given in Part I. | 23e. Dio | I tobacco use cor | ntribute to the cause of c | death? |
| COLOS W requires | n sign uld be | d by | Myelodropla | stic Sunda | eme | | | 10 | Yes 2 No | 3 Probably 4 | Unknown |
| aw re | s bee 2 sho | Completed | anemia Sec | inclam to | mula de | edah. | Sund | 24a. Ws | | Were autopsy findings | available |
| ع ع | is certificate hes director, page 2 | mo; | Idia an Hai | 11000 | 610 | 36 | 7,00 | aut per 12 Yes | opsy formed? 2 \(\subseteq \text{No} \) | prior to completion of codeath? 1 Yes 2 No | ause of |
| ie ie | ctor. | Bec | 25. Was case referred to medical examiner? | morney | ribre | > 1.5 | 26. Place | of Death (Check only | | 763763 | |
| Physic V | .e. ⊕ | ဥ | 1 Yes 2 No | | ☐ ER/Outpatie | III 3 DOA | | sing Home 5 Re | | | |
| ding F | fter | iio | 27. Manner of Death Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | W | | | how injury occu | rred | |
| VISION OF VICE Attending Physicien: | ctor: | ertification: | 2 Accident investigation 3 Suicide 6 Could not | be Diagonal Injury At | t home farm et | | Yes 2 N | | /Street and Num | ber or Rural Route Num | a hor |
| S of a | Direc d in by | ert | 4 Homicide determined | building, etc. (Spe | ecify) | reet, factory, offic | A | | own, State) | Del Ol Hural House Hull | iber, |
| pspite | neral Dir y filled in | alc | 29a. Certifier 1— Certifying P | hysician: To the best of my k | knowledge, dea | th occurred at the | time, date and | place, and due to th | e cause(s) and m | anner as stated. | |
| To the Hospitel or Attendi | To the Fur completely | Medical | (Check only 2 Medical Exa | miner: On the basis of exami and manner stated. | ination and/or ir | vestigation, in m | y opinion, death | h occurred at the time | e, date and place | and due to the cause(s | s) |
| To | Com | Σ | 29b. Signature and title of certifier | | | | ense number | | | ed (Month, Day, Year) | |
| . , | 01 | | VmU | mo | | | 5763 | 7 | Nov. 2 | 5,2005 |) |
| 100 | | | 30. Name and address of person who | 7 | . 0 . | Print) | | Ac | 15 | DILLA | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Sig | ection) | 1 mx | Lan | www. | ns W | 10 21701 | |
| | Registr | _ | | hote & | 15 | 18 0 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month \mathbf{P}^{M} November 21, 2005 9:06 Allen R. Smith Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Cheverly

ar 1 Year I If Under 24 Hrs. Prince Georges Hospital Prince Georges 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. iast birthday) 1**№** M 2□ F Yrs 1921 249-18-2435 84 July 6, South Carolina Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland Prince Georges Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7808 Jacobs Drive 20770 U.S.A. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Folces:
1 Xes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 20 Married 1 ☐ Yes 2x No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Metropolitan Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Smith Fannie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia H. Smith/wife 7808 Jacolbs Dr. Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 11/29/2005 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify, 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd. Brentwood, MD 20722 and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of) Hemoptysis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Tracheal Ulcer that initiated events resulting in death) Last Due to (or as a consequence of) Ventilator Dependant Respiratory Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**X X**Io 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 datural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Cheverly, Md 20785 MD Ophnell Cumberbatch,

State Registrar

Physician

/Medical

Examiner

Funeral

Director

r than "naturs!, or iteme 23a or 28a-f show the Medical Examinar must be notified at

Hygiene.

1 and 2 should be Health and Mental

Department of H important: If its eny injury or ot once.

Physician

/Medical

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After 1

Director

To the Funeral

To the Hospital or Attending Physician:

Direct

Funeral

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Completed

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death v

Saltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrag's Signature

| | | | | 1 _ State | State of Ma | ryland / I | | artment of He | | | 200 | <u> </u> | oncl |
|-----|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------|------------------|-----------------------------------------------------------------------|--------------------------|-----------------------------------------------------|----------------------------------|------------------|-----------------------------------------------|
| | | | 7 | Registrar 1. Decedent's Name (First, Middle, Last) | | | | THICALE OF D | eaur | 2. Date of Death | g. No. | <u> </u> | 3. Time of Death |
| _ | | Physici /Medic | | John | Α. | S | ріе | ece | | November | ^{Day} 24, 2 | 005 | 2:55 P M |
| | | Examin | | 4a. Facility Name (If not institution, give str | | | | 4b. City, Town, or L | | | 4c. County | of Death | |
| | | A. Francist | | Hospice of Baltimor 5. Social Security Number 6. Sex | | ist Cen | | Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | | 9. Birthol | |
| | | Funeral Director | | 196-28-7605 | 7. Age | 70 | Yrs. | Months Days | Hours Min. | Jan. 20 | ,1935 | Pen | ace (State or Foreign try) nsylvania |
| | | and | | Usual Residence of Decedent 10a, State 10b, County | | 10c. City, Tow | vn or Lo | cation | | | | 10 | Od. Inside City Limits |
| | | Maryl | tor | Maryland Baltimore | | Tows | on | | | | | | 1 ☐ Yes 2 🕱 No |
| | | death with the Maryland me 23a or 28a-f ehow fred by notified at | Director | 10e. Street and Number | | | | 10f. Zip Code | | 10 | g. Citizen of V | /hat Coun | try? |
| | | e 23a | | 601 Shelley Road | I Was Decedes F | ives in ALC | 10.1 | 21286 | | | | S.A. | on Indian |
| | 10 | r Item | Funerai | 11. Marital Status 1 Never Married 2 Married | !. Was Decedent E Armed Forces? 1 W es 2 □ N | | | Was Decedent of Hisp f Yes, specify Cuban, | Mexican, Puerto | Rican, etc.) | | k, White, e | |
| | 903 | ours a | by | 3 ☐ Widowed 4 ☐ Divorced | 1 Wes 2 N ff Yes, Give 191 Year or Dates: | 53-1957 | | 1 ☐ Yes 2 ☐ No | Specify: | | Specify | Wh | ite |
| | 15-(| be filed within 72 hours after death with the Marylar lat Hygiene. Id other then "natural", or iteme 23a or 28a-1 show event, it a Medical Exerciter cust ke notified a | Completed | 15. Decedent's Educa (Specify only highest grade | | 16a | . Deced (Give | lent's Usual Occupati kind of work done dui DO NOT use retired) | on ring most of worki | ng 1 | 6b. Kind of Bu | siness/Ind | lustry |
| | 212 | d withii giene. r then | omp | Elementary/Secondary (0-12) | College (1-4or 5- | | | urity Offi | | | U.S. Go | vern | ment |
| | pu | al Hyg | ВеС | 17. Father's Name (First, Middle, Last) | | | | | | (First, Middle, M. | | | |
| | Maryland 21215-0036 | 12 should be filed within n and Mental Hygiene. 7 le marked other then "reumatic event, it is the | 얼 | Thomas H. 19a. Informant's Name/Relationship (Type | Spiece | 101 | - NA-00- | ng Address (Street an | Viola | | rby | C4-4- 7 - | 0-4-1 |
| | Ma | s 1 and 2 should if Health and Men itam 27 le marke other traumatic | | Nance B. Spiece | Wife | | | Shelley Ro | | on, Mary | | 21286 | Code) |
| | ore, | of Hea | | 20a. Method of Disposition | | 20b. Place o | of Dispo | sition (Name of | | | Oc. Location - | | wn, State |
| 3 | altimore, | Page tment tant: It | | 1 XBurial 2 Cremation 3 Rei | | Dulan Mem | ori | yalley al Gardens | 11-30 | -2005 | | | |
| 8 | Ball | permit. Pages 1 and 2 Depurtment of Health a Important: If item 27 le any injury or other tra | | 21. Signature of unival service idensee | | | 1 | Name and Address 1050 York | Nu | ck Towso owson, M | | | ome, Inc. |
| 1 | | 24 A. A. | | 23a. Part1. Enter the disease, or complete shock, or heart failure. List only one | ations that caused | the death. Do | _ | | | | | | Approximate Interval Between |
| , | | Physician | | fmmediate Cause (Final disease or condition | Rena | Cell. | | ran w | | | | 3 | Onset and Death |
| 3 | | /Medical Examiner | | resulting in death) | Due to (or as a | consequence | of): | | | | | | (0) |
| .23 | | | Je. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | t consequence | of): | | | | | | |
| 24 | | ocuted nd transit | Examine | that initiated events C. | | | | | | | | | |
| 1 | 8760, | that the death certificate be executed ed by the attending physician and detached for use as the burial-transit | <u>a</u> | resulting in death) Last | Due to (or as a | consequence | of): | | | | | | |
| 3 | 9 | ificate g phys as the | 유 | d. | | | | | | | | | |
| 3 | Вох | death certific e attending p od for use as | an/M | 23b. was decedent pregnant | c. ff yes, outcome o | | 3 [| Ectopic pregnancy | | | | of deliver | • |
| 700 | O. E | he dea the at | Physician/Med | in the past 12 months? 1 Yes 2 No 9 Unknown | 4☐Pregnant at 9☐ Unknown | time of death | 5 | Other (specify) | | | Mor | itri | Day Year |
| | ۳. | requires that the teen signed by th hould be detache | by Ph | Part II. Other significant conditions contr | ibuting to death bu | t not resulting | in the u | nderlying cause given | in Part I. | 23e. Did toba | cco use contr | ibute to the | e cause of death? |
| | rds | w requires that been signed be should be det | | | | | | | | 1 🗆 Yes | 2 🗆 No | 3 🗌 Proba | ably 4 Unknown |
| 3 | Record | a a S S S S S S S S S S S S S S S S S S | ompleted | | | | | | | 24a. Was an autopsy | 24b. V | Vere autop | sy findings available optetion of cause of |
| 0 | a E | Th ate pag | O | OF Western Country of the Country of | | | | | | | XINO 1 | eath? | 2 No |
| , | <u> </u> | Attending Physician: r death. ector: After this certific by the funeral director. | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | spital: | nt 2 ER/O | utpatier | | | n <i>(Check only</i> o <i>ffe</i> me 5 ☐ Residen | | or (Specify | HOSPICE |
| 3 | n of | ng Phys Mer this | on: T | 27. Manner of Sath 1 Natural 5 ☐ Pending | 28a. Date of Injur (Month, Day | y Year) 28b. | Time of | 28c. Injury a Work? | it : | 28d. Describe hov | | | |
| 18 | vision | l or Attending Ph after death. Director: After th in by the funeral | ertification: | Accident investigation 3 Suicide 6 Could not be | 28e. Place of Inju | int - At home f | arm ete | | s 2 No | 28f. Location (Stre | et and Numbe | ar or Pural | Poute Number |
| Şp | 2 | o al io | Certif | 4 Homicide determined | building, etc | . (Specify) | u, 311 | eet, ractory, office | | City or Town, | State) | , or rigital | TIQUE RUITIDET, |
| | | To the Hospital of within 24 hours at To the Funeral D completely filled it | edical (| (Check only 2 Medical Examine | r: On the basis of | examination ai | e, deatl | occurred at the time, vestigation, in my opin | , date and place, a | and due to the cau | ise(s) and mai e and place, a | nner as sta | ated. the cause(s) |
| | | To the within 2 To the complet | Med | one) 29b. Signature and title of certifier | and manner sta | ted. | | 29c. License r | number | 29 | d. Date signed | (Month, E | Day, Year) |
| |) | r s + 5 | | Exerdale N | Level | 2lu | \circ | 100 | 5643 | , 1 | 1/24 | 120 | 05 |
| | 17 | 147 | | 30. Name and address of person who com | ~ / | eath (Item 23a) | (Туре, | Print) Wes SW | at/E | Roofs | Mi | 2,2 | 04 |
| | 100 | Sta | te | 31. Date filed (Month, Day, Year) | . Registra | r's Signature | A. C. | N. | | | | | ~ 1 |
| | 1 | Registr | ar . | NOV 2 8 2005 | A Comment | 13. | 108 | | | | | | |

| | | | State of N 1 - State Amend Item 5 per fh G8 | laryland / Depa 349 11-28-05 | artment of H | lealth and M Death | Mental Hyg | gierie () () 5 | 38065 |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------|--------------------------------------------|----------------------------------------|--------------------------------------------------|--------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | | - | 2. Date of Dea Month | | 3. Time of Death |
| | Physicia /Medic | | IRENE | | SUGAR | | NOVEMNE | R 23, 2005 | 10:45 A M |
| | Examin | er | 4a. Facility Name (If not institution, give street and numbe | 7 | 4b. City, Town, or | Location of Death | | 4c. County of Dea | |
| | | | FUTURE CARE CHERRYWOOD 5. Social Security Number 6. Sex 7. A | ge (In yrs. last birthday) | If Under 1 Year | REISTERS If Under 24 Hrs. | TOWN 8. Date of Birth | | IMORE |
| | Funeral Director | | 212-24-9172 | 77 Yrs. | Months Days | Hours Min. | 08/31/1 | 928 | hplace (State or Foreign buntry) MD |
| - | D | | Usual Residence of Decedent | | | | 100,00,00 | | |
| | show | ž | 10a. State 10b. County | 10c. City, Town or Lo | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | the M | ecto | MD BALTIMORE 10e. Street and Number | REISTERS | 10f. Zip Code | | | 10g. Citizen of What Co | Λ |
| | 3a or | Funeral Director | 510 BOND AVENUE | | 21136 | | | U.S.A. | ouritry ? |
| | death ms 2; | nera | 11. Marital Status 12. Was Deceder | t Ever in U.S. 13. V | Vas Decedent of Hi f Yes, specify Cuba | ispanic Origin? (Sr | ecify Yes or No- | | |
| 2 | or ite | | 1 Never Married 2 Married 1 Yes 2 Married 3 X Widowed 4 Divorced Year or Dates |]No | r res, specify Cuba I□ Yes 2 No | Specify: | Hican, etc.) | | e, etc. √HITE |
| 3 | d within 72 hours after death with the Maryland plane. Than "natural", or Items 23a or 28a-f show the Medical Exaction in the notified at | d by | | | | | | Эрвелу. | |
| <u>.</u> | | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give | lent's Usual Occupa kind of work done o DO NOT use retired | ation during most of worl I) | ing | 16b. Kind of Business | Industry |
| 7 | a filed within I Hygiene. other than " | mo | Elementary/Secondary (0-12) College (1-4o | CLERK | | , | | STATE OF MA | ARYLAND |
| ġ | file Hyg othe /ent, | BeC | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | e (First, Middle, | Maiden Sumame) | |
| <u> </u> | | 2 | VICTOR | MILLER | 1 | MAY | | STELM | ACH |
| Z Z | 2 2 2 2 | | 19a. Informant's Name/Relationship (Type, Print) | | | | | r, City or Town, State, | |
| n, | s 1 and of Health Item 27 other tr | | LYNN RUDDIE / DAUGHTER 20a. Method of Disposition | 20b. Place of Dispos | sition (Name of | | Date | WN, MD 2113 20c. Location - City or | |
| | 90 = 5 | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | HEBREW YC | natory`or other plac | | 5/2005 | • | |
| | permit. Pag Department Important: f Imy injury o | | 21. Signature of Funeral Service Ligenses | 2573 | . Name and Addres | ss of Facility | 1 | WOODLAWN, I | |
| Ď | permi Depa Impo any ii | | Mundel Tyngo | 1 | SOUU DEIC | SI TEDETOWN | DOVD DOVD | SON & BROS | ., INC. |
| | | | 23a. Part I. Enter the disease, or complications that caus shock, or heart failure. List only one cruis on each | ed the death. Do not enter | er the mode of dying | g, such as cardiac | or respiratory ari | rest, | Approximate Interval Between |
| | Physician | | | | lees 6 | light | Loot | • | Onset and Death |
| | /Medical Examiner | | Due to (or a | s a consequence of): | | J | | | |
| | | e | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | s a consеqueлсе of). | | | | | |
| | d ansit | Examin | | | | | | | |
| Š | be executed ician and burial-transit | Еха | and the standard of the standa | s a consequence of): | | | | | |
| 2 | ate hys | dicai | d | | | | | | |
| o X O | ding p | a) | IF FEMALE: 23c. If yes, outcom | e of programmy | | | | | |
| 0 | atten for us | cian | in the past 12 months? | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of del Month | ivery Day Year |
| j. | the d | Physician/M | 1 Yes 2 No 4 Fregrant 9 Unknown 9 Unknown | at 1,110 of abati. | Citici (Specify) | | | | |
| , T | The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as | by Pi | Part II. Other significant conditions contributing to death | but not resulting in the ur | ndertying cause give | en in Part I. | 23e. Did to | bacco use contribute to | the cause of death? |
| ž | equire en sig ould b | ted k | Diabetis Hell | etus Le | weller | . defe | , da si | 2 □ No 3 □ Pr | obably 4 □Unknown |
| records, | law ri as be | ompleted | | | | | 24a. Was a autop: | | itopsy findings available completion of cause of |
| | | Con | | | | | perfor | med? death? 2 No 1 ☐ Yes | |
| VII | ician certifi ector | Be | 25. Was case referred to medical examiner? | | Othe | 26. Place of Dea | h (Check only or | ne) | |
| 5 | ding Physician: After this certific funeral director, | . To | 1 ☐ Yes 2 No 1 ☐ Inpa 27. Manner of Death 28a. Date of Ir | | t 3 DOA | Nursing H | | ence 6 Other (Specow injury occurred | cify) |
| 0 | th. : Afte | itior | 1 Natural 5 Pending (Month, D | ay Year) Injury | Work | k? ` Yes 2 □ No | | on anjuly occurred | |
| JIVISION | ar dea ector by th | ertification; | 3 Suicide 6 Could not be determined 28e. Place of 1 | niury - At home, farm, streetc. (Specify) | eet, factory, office | | 28f. Location (S City or Tow | itreet and Number or Ru | iral Route Number, |
| 5 | ital or irs afte ral Div led in | O | | | | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; to | edical | 29a. Certifier (Check only one) Certifying Physician: To the beside and manner and manner | of examination and/or inv | occurred at the time vestigation, in my op | ne, date and place, pinion, death occur | and due to the c red at the time, o | ause(s) and manner as date and place, and due | stated. to the cause(s) |
| | Fo the within Fo the comple | Med | 29b. Signature and title of certifier | | 29c. License | e number | 2 | 29d. Pate signed (Mont | h, Day, Year) |
| | | | 1 Cont | | 125 | 112 | | 11 23 200 | 5 |
| | 10 | | 30. Name and address of person who completed cause of | | Print) | Scrite | 1 611 | n'was Ni | 100 |
| | , | | Tahoora Kaldaya 20 | 1 | | ا معادل | | MDIZIL | ř |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Regis | trar's Signature | use o | | | | |
| | | | NOV 2 8 2005 | Sel Sel Propos | _ | | | | |

| | | 1 - State Registrar | State of Maryland | | artment <i>tificate</i> | | | | giene, | 2005 | 3800 | 66 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------|------------------------------|------------------------------|------------------------------|------------------------------------------------|----------------------|------------------------------------------|----------------------------------------|----------------|
| Physicia | an. | Decedent's Name (First, Middle, Last) | | | | | | 2. Date of De Month | ath Day | Year | 3. Time of Dea | |
| /Medic | al | DAVID 4a. Facility Name (If not institution, give st. | root and number | | SILB | | ocation of l | Novembe | 1 2 | 3, 2005 County of Death | 4:52 | PM |
| Examin | er | Sinai Hospital of | Boltimor | | | timo | | 249 | 40. | County of Death | N/A | |
| Funeral | | 5. Social Security Number 6. Sex 1 X | 7. Age (In yrs. las | t birthday) Yrs. | If Under 1 Months | Year Days | If Under 24 Hours | Hrs. 8. Date of Bir Month, Da | th Ya Yaarb | 9. Birthp | lace (State or Fo | oreign |
| Director | | Usual Residence of Decedent | - 63 | 113. | | | | 10/02/ | 1922 | | POLAN | ע |
| ehow | ŗ | 10a. State 10b. County | 10c. City, | | | | | | | 1 | 0d. Inside City Li | |
| the M 28a-f | Director | MD BALTIMOI 10e. Street and Number | KE BA | LTIMO | 10f. Zip | Code | | | 10a. Citiz | zen of What Cour | 1 ☐ Yes 2√X | |
| th with 23a or | ai Di | 2905 CHOKEBERRY (| COURT | | | 209 | | | - | U.S.A. | | |
| er dea Items | Funerai | T. Hallar States | 2. Was Decedent Ever in U.S. Armed Forces? | 13. | Was Decede f Yes, speci | ent of His fy Cuban | panic Origir , Mexican, I | n? (Specify Yes or No Puerto Rican, etc.) | . 1 | 14. Race - Americ Black, White, | | |
| be filed within 72 hours after death with the Maryland the Hygiene. I have a chernes 23a or 28a-f ehow do ther than "natural", or items 23a or 28a-f ehow event, I'm Medital Evanimer must be notified at | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: | | 1 ☐ Yes 2 | X No | Specify: | | | Specify: WHI | TE | |
| 72 ho | Completed | 15. Decedent's Educa (Specify only highest grade | | (Give | dent's Usual kind of worl | done du | | f working | 16b. Kir | nd of Business/Ind | dustry | |
| within ene. than | dmc | Elementary/Secondary (0-12) | College (1-4or 5+) 5+ | | DO NOTUS RICAL | | INFED | | BEN | DIV | | |
| al Hygi | BeC | 17. Father's Name (First, Middle, Last) | <u> </u> | LLLUI | MICHE | | | s Name (First, Middle | | | | |
| should be filed within and Mental Hygiene. Imarked other than Imatic event, Ite Ma | To | GABRIEL | | | BER | | FRAN | | | | SZKIEWIC | ;Z |
| and 2 sho salth and n 27 ie m | | 19a. Informant's Name/Relationship (Type HALINA SILBER / N | | | ng Address CHOK | | | or Rural Route Numb URT - BALT | | Frown, State, Zip | , | |
| | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re | 20b. Plac | e of Dispo | sition (Nam matory or oti | e of | | Date | | cation - City or To | | |
| Pa men ant: ury | | 4 ☐ Donation 5 ☐ Other (Specify) | BETH | - | OH CO | 1.00 | | /25/2005 | WOOL | DLAWN, M | D | |
| permit. Depart Import any nj | Î | 21. Signature of Funeral Service Licensed | Cattle | 22 | 2. Name and | | | SOL LEVI | | | | |
| ₹. | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one | ations that caused the death. | Do not ent | er the mode | RETS of dying | Such as ca | OWN ROAD - urdiac or respiratory a | rrest, | ESVILLE, | Approximate Interval Between | |
| Physician | | Immediate Cause (Final disease or condition | | accu | ol . | Inte | re#104 | | | | Onset and Dear | |
| /Medical Examiner | | resulting in death) | Due to (or as a conseque | nce of): | | | | | | | | |
| | Jer | Saquentially list conditions if any, leading to immediate cause. Enter Underlying | | | | | | | | | | |
| and | Examin | Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| cate be executed physicien and sthe burial-transit | dical E | | | | | | | | | | | |
| The taw requires that the death certificate be the has been signed by the attending physicis aggle 2 should be detached for use as the bur | Medic | U | | | | | | | | | | |
| ath cer attendin | lan/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | c. If yes, outcome of pregnand | eath 3 | Ectopic pre | | | | 2 | 3d. Date of delive | ery Day Year | ır |
| the de | Physician/Me | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at time of dea 9□Unknown | th 5L | Other (spe | icify) | | | | | , | |
| gned b | by Pi | Part II. Other significant conditions cont | | _ | | • | | 23e. Did 1 | obacco us | se contribute to th | | |
| w requires to been signer should be | eted | Lung Concer, | the pectoo phic | u | udio | ngo | wrug | _ 10 | Yes 2 | No 3□ Prob | bably 4 Winkr | nown |
| has to | Completed | | | | | | | 24a. Was | | 24b. Were auto prior to con death? | psy findings avai mpletion of cause | ilable e ol |
| vital ician: T sertificate ector, pa | 0 | 25. Was case referred to medical | | | | | 26. Place o | 1 ☐ Yes f Death (Check only of | 2DXNo | 1 ☐ Yes | 2 No | |
| Physic Physic rthis ce | To B | TI THE ZINO | 13 | R/Outpatier | | | 4 🔲 Nurs | ing Home 5 Resi | | | v) | |
| ding F. After funera | tlon: | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 8b. Time o Injury | f 28 | 3c. Injury Work? 1 □ Y | at ? es 2 ∐No | 28d. Describe | how injury | occurred , | | |
| LIVISION I or Attending after death. Director: After in by the fune | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At hom building, etc. (Specify) | e, farm, sti | eet, factory, | office | | 281. Location (City or To | Street and | d Number or Rura | l Route Number, | , |
| pital or urs aftra sral Direction | | | | | <u> </u> | | | | 0055 | | | - |
| To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as | dicai | 29a. Certifier Certifying Physical Check only one) | cian: To the best of my knowler: On the basis of examination and manner stated. | edge, deat n and/or in | n occurred a vestigation, | it the time in my opi | e, date and nion, death | place, and due to the occurred at the time, | cause(s) date and | and manner as si place, and due to | ated. the cause(s) | |
| To th within To the compl | Me | 29b. Signature and title of certifier | | | | License | | | | e signed (Month, | | |
| 2 | 1 | > gradous her | te , MD | | R | ES- | 000 | | Noven | nber 23 | , 2005 | |
| 3, | | 30. Name and address of person who cor | npleted cause of death (Item 2 AITE, IYD | (3a) (Type, | Print) | tlos. | retal | of Bo | lti'ue | OR | | |
| Sta | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Siegatu | | Es . | / | | -1 | | | | |

DAVID

Patreut kuowin as

| | | | For State Registrar | State of Marylar | | rtment of tificate of | | Mental Hy | giene Reg. No. 005 | 38067 |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------|-------------------------------------------|-------------------------------------------------------|-----------------------------------------------|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last Dokoth y | uknek | | | | 2. Date of De Month | 2 ^{Day} OS | 3. Time of Death 223 M |
| | Examin | | 4a. Facility Name (If not institution, give | street and number) Bay view Mcc | d Ctrc | _ | or Location of Dea | | 4c. County of Death | more |
| | Funeral Director | GE-1 | 5. Social Security Number 6. Se | | | If Under 1 Yea Months Days | r If Under 24 Hr | s. 8. Date of Bir (Month, Da | th 9. Birth Cou | place (State or Foreign intry) |
| | how | | Usual Residence of Decedent 10a. State 10b. County | | ity, Town or Loc | | | | | 10d. Inside City Limits |
| | r 28e-f show | Funeral Director | MD Baltin | none | Bal. | 10f. Zip Code | u | | 10g. Citizen of What Cou | Yes 2 No |
| | 23a or | raiD | | odley Roa | | 1 | 21222 | | usa | |
| 5-0036 | iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or iteme 23a or 28e-f show or other traumatic event. If a Medical Exartificat must be multified at | Ď | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Secedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | lf . | Vas Decedent of Yes, specify Cu | Hispanic Origin? (ban, Mexican, Pue D Specify: | Specify Yes or No ito Rican, etc.) | 14. Race - Amer Black, White Specify: 1W | , etc. |
| 215-(| within 72 h ene. then netu | Completed | 15. Decedent's Edu (Specify only highest grad | ucation de completed) College (1-4or 5+) | 16a. Decede (Give k life. D | ent's Usual Occi rind of work don O NOT use retir | upation e during most of w ed) | orking | 16b. Kind of Business/In | ndustry |
| 21 | filed with Hygiene. hther the | | 12 years 17. Father's Name (First, Middle, Last) | Conage (1-401 5+) | Hou | sewife | 18 Mother's Na | ama (First Middle | Own Home | |
| Maryland | S should be filed within and Mental Hygiene. Is marked other then aumatic event, I'm M | To Be | Floyd Quirk | | | | | ia Dudle | | |
| | and 2 sho lealth and m 27 is m | | 19a. Informant's Name/Relationship (T) Leonard Paul Turne | | 1 | | | | er, City or Town, State, Zi 1d. 21222 | p Code) |
| ore, | ages 1 and nt of Health : if itsm 27 or other tr | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F | Removal from State | Place of Dispos cemetery, cremi k Lawn (| ition (Name of atory or other pi | ace) NOVE | ember 2005 | 20c. Location - City or T | |
| Baltimore, | permit. Pagi Depertment Important: i eny injury o | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens | | | | | | Dundalk, MI Dundalk, P.A. Dundalk, MD. | |
| | 405#a | | 23a. Part1. Enter the disease or comp shock, or heart failure. List only o | lications that caused the dea | th. Do not ente | 110 So1 | lers Poir | nt Road, | Dundalk, MD. | Approximate |
| | Physician /Medical Examiner | | shock, or heart failure. Light only of Immediate Cause (Final disease or condition resulting in death) | | | |) failu | | | Interval Between Onset and Death |
| | uted I | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (ur as a consec | quanca of). | | | | | |
| 8760, | cate be executed only sicien and the burial-transit | | that initiated events resulting in death) Last | Due to (or as a consec | quence of): | | | | | |
| 9 | entificate ling phy: e as the | Medic | IF FEMALE: | 0. | | | | | | ň |
| .O. Box | The law requires that the death certificate be executed tte hes been signed by the attending physicien end tage 2 should be detached for use as the burial-transit | Physician/Medical | 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown | al death 3 □E | Ectopic pregnan Other (specify) | су | | 23d. Date of deliv Month | rery Day Year |
| rds, P. | quires that n signed b | þ | Part II. Other significant conditions co | ntributing to death but not res | sulting in the und | derlying cause g | even in Part I. | 23e. Did t | obacco use contribute lo | the cause of death? |
| il Records, | | Completed | | | | | | 24a. Was auto perfo 1 Yes | an 24b. Were autopsy prior to codeath? | opsy findings available impletion of cause of |
| Vita | Physician: Th this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? | Hospital: 1 Inpatient 2 | ER/Outpatient | 3□ DOA O | thor | eath Check only | one) dence 6 ⊟Other (Speci | £.) |
| on of | After fune | tion: T | 27. Manner of Death Natural 5 Pending | 28a. Lette of Injury (Marth, Day Year) | 28b. Time of Injury | 28c. Inj | | | how injury occurred | <u>(y)</u> |
| Division of Vital | To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | ome, farm, stre | | | 28f. Location (City or To | Street and Number or Rur wn, State) | al Route Number. |
| | To the Hospitel within 24 hours a To the Funeral completely filled | Medical C | 29a. Certifier (Check only one) 2 Medical Examination | sician: To the best of my known iner: On the basis of examination and manner stated. | nwledga, death atlog and/or inve | scourad at the estigation, in my | time date and place opinion, death occ | e, and dual to the curred at the time, | cause(s) and marmer as t date and place, and due t | stated. o the cause(s) |
| | To the within To the comple | Med | 29b Signature and title of certifier | and manny stated. | 7 | | ise number | | 29d. Date signed (Month, | |
| | | | 20 Alemand | 3 | mo | RE | ES-00 | 0 | 11.24.0 | 5 |
| . — | (e | | 30. Name and address of person who con Rupali Cha | dha MD | 4940 | Easter | n Ave. | Baltin | 11.24.0 more, Md 6 | 4224 |
| | Sta Registi | | 31. Date filed (Month, Pay, Year) 8 | 32. Redistrar's Sign | ature | beil | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No...

Day

25,

4c. County of Death

2005

Baltimore

MARYLAND

USA

14. Race - American Indian. Black, White, etc.

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2X No

1:0140

2. Date of Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY LOW M. D.

NOV 2 8 2005

31. Date filed (Month, Day, Year)

For State Registrar

Specify. WHITE 16b. Kind of Business/Industry MARTIN MARIETTA 20c. Location - City or Town, State COCKEYSVILLE, MD THE JOHNSON FUNERAL HOME P.A. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ormea? 2 **X**No 25 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 7601 OSLER DRIVE TOWSON MARYLAND 21204

State Registrar D 24034

State of Maryland / Department of Health and Mental Hygiere 1 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dinanauth Tiwari November 22, 2005 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3822 37th Pl. Prince George's Brentwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 11**X**M 2□ F Yrs Director 578<u>-08-0853</u> 76 March 11, 1929 Guyana Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Ever the remait to notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3822 37th P1 20722 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: East Indian 3 Widowed 4 Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Shoreham North 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental I 2 Paltan Tiwari Dulari Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 sh Dep. rtment of Health and Important: If Item 27 Is rr any njury or other traum Munshwar Davndra Tiwari/Son 3822 37th St. Brentwood, MD 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 11/24/2005 Brentwood, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Mirane 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that calls of he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus I Years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit attending physician and C. resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End Stage Renal Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypothyroidism Hypertension 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 1 XNatural 5 Pending Injury death. 1 Tyes 2 No 2 Accident investigation after death the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide ō To the Hospital o within 24 hours af To the Funeral D 29a. Certifier Medicai 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42403 November 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Raj Mathur, 106 Irving Street, NW #218, Washington, DC 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

| | | _ rui | State of Maryla | nd / Depa | artment of H | lealth and | Mental Hyg | F1 F1 F1 F1 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------------------|--------------------------------------------------|
| | | State Registrar | | Ce | rtificate of I | Death | | eg. Ma. UU5 | 38070 |
| Physic | | 1. Decedent's Name (First, Middle, Last) | Vukov | | | | 2. Date of Dea Month | Day Year | 3. Time of Death - 23 20 M |
| /Medi Examir | | 4a. Facility Name of not institution, give si | | | 4b. City, Town, or | r Location of Deat | h | 4c. County of Dea | |
| LAGIIII | | Johns Hupkins ! | BAYYEL Care | Center | | more C | | N/A | |
| Funeral Director | | 5. Social Security Number 6. Sex 217-24-4380 | 7. Age (In yrs | . last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | (Month, Day | | thplace (State or Foreign ountry) HIO |
| yland | | 10a. State 10b. County | 10c. C | ity, Town or Lo | ocation | | | | 10d. Inside City Limits |
| Ba-fel | ctor | MD. N/A | | BALT | IMORE | | | | Mo 2 □ No |
| with th | Funeral Director | 10e. Street and Number | mp.==== | | 10f. Zip Code | 1004 | 1 | log. Citizen of What C | |
| ns 23 | era | | TREET 2. Was Decedent Ever in 1 | J.S. 13. | Was Decedent of H If Yes, specify Cuba | 1231 lispanic Origin? (S | Specify Yes or No- | U.S.A | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehow any injury or other traumatic event. I'm Medical Examinar must be notified at some. | b | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▓ Divorced | Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: | | If Yes, specify Cuba 1 ☐ Yes 2 X No | an, Mexican, Puerl Specify: | to Rican, etc.) | Specify: | te, etc. HITE |
| 72 ho | Completed | 15. Decedent's Educ (Specify only highest grade | ation completed) | 16a. Dece | dent's Usual Occup | ation during most of wo | rkina | 16b. Kind of Business | |
| within ne. | mpje | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired ASHTER | d) | 9 | ם השתא דד | |
| filed y Hygie other t | ပိ | 10 17. Father's Name (First, Middle, Last) | | | ASHIEK | 18. Mother's Nar | me (First, Middle, | RETAIL Maiden Surname) | |
| Id be Mental rked c | To Be | CARL REDIFER | | | | WAUNE | TI BAU | ERMEISTE | R |
| 2 should and he is ma | | 19a. Informant's Name/Relationship (Typ | | | | | | r, City or Town, State, | |
| Tand 1 and 1 | | ANNA MAE NEWELL 20a. Method of Disposition | · | | | | , BALTIM | ORE, MD. | |
| ages nt of h | | 1 ☐ Burial 2XXX remation 3 ☐ Re | illoval ilolli State | | osition (Name of matory or other place | 1 | | 20c. Location - City of | |
| injung | | *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Barvice License | | YVIEW | CREMATO Name and Address | | | | E, MARYLAND |
| Departing Department of the police of the po | | Mallane | S. Fred | | 1901 EAS | ZEILER STERN A | VENUE, B | UNERAL HOALTIMORE | ME.21231 |
| The second | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on | ations that caused the dea cause on each line. | ath. Do not en | ter the mode of dyin | ng, such as cardia | c or respiratory arr | rest, | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition resulting in death) | | | ardial. | interesti | in | | Onset and Death |
| /Medical Examiner | | Tooling in docum | Due to (or as a conse | quen e of): | | | | | |
| | Je. | Sequentially list conditions, if any, leading to immediate cause Enter Industrying | Due to (or as a conse | quence of): | | | | | |
| cate be executed physician and the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| e be exe sician a | | resulting in death) cast | Due to (or as a conse | quence of); | | | | | |
| licate physics the b | edicai | d | | | | | | | |
| onding use a | n/Me | IF FEMALE: 23b. Was decedent pregnant | c. If yes, outcome of pregi | | 76 | | | 23d. Date of de | livery |
| The could us, T.C. BOX 00100, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/M | in the past 12 months? 1 Yes 2 W | 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown | | □Ectopic pregnancy □ Other (specify) | - | | Month | Day Year |
| s that | by Pt | Part II. Other significant conditions con | ributing to death but not re | sulting in the u | inderlying cause giv | en in Part I. | 23e. Did to | bacco use contribute t | o the cause of death? |
| w requires to been signed should be | | endstace renal | disease | conges | tin home | <u>r</u> | 1 □ Y | es 2□No 3□P | robably 4 Hinknown |
| e lawr has be | Completed | tailure, diase | to melli | tus | | | 24a. Was a autops | an 24b. Were a prior to | utopsy findings available completion of cause of |
| ding Physician: The lav h. After this certificate has funeral director, page 2 | - | enterocutaneous | fistula | | | | | 2 → No 1 □ Ye | s 2 No |
| vical sician: s certifica lirector, p | o Be | 25. Was case referred to medical examiner? | ospital: | TER/Outpatie | nt 3 DOA Oth | | ath (Check only or | ne) ence 6 □Other (Spe | noihe) |
| g Phy g Phy ter this | ı. | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time o | This is the | | 7 | ow injury occurred | scriy) |
| tending eath. or: Afte | catic | 1 Abdural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | (, 2, 1, | ,, | | Yes 2 □ No | | | |
| cal or Atter s after dea in Director | Certification: | 4 Homicide determined | 28e. Place of Injury - At building, etc. (Spec | home, farm, st cify) | reet, factory, office | | 28f. Location (S City or Town | treet and Number or R n, State) | ural Route Number, |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. | Medical | 29a. Certifier 1 Check only one) 1 Medical Examin | ician: To the best of my kr er: On the basis of examir and manner stated. | nowledge, deal nation and/or in | th occurred at the tin evestigation, in my o | me, date and place opinion, death occu | e, and due to the curred at the time, d | ause(s) and manner a late and place, and du | s stated. e to the cause(s) |
| To ti To ti comp | Ň | 29b. Signature and title of certifier | 1/_ | | 29c. Licens | se number | 2 | 29d. Date signed (Mon | th, Day, Year) |
| 0 | / | Millet Jeller | dow MC | 2 | D3- | 15/6 | | 11-24- | 2005 |
| 150 h | | 30. Name and address of person who co | mpleted cause of death (Ite | m 23a) (Type | Print) | Rank | Cialo | R.1.6 | 2005- AD 2/224 |
| St | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | nature // | 1 (11/1/1) | My Weam | -11016 | NE TIME | THE HELY |
| Regist | | NOV 9 0 2 | nns Serence | A. A. | poores! | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
1- Registrar Reg Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 1, 2005 **Physician** 6:47 A William N. Wade /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Center Cheverly Birthplace (State or Foreign Country)
 DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show the Medical Examiner must be notified at Yes 2 No Director Washington DC the 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number items 23a or USA 20010 3725 New Hampshire Ave., NW Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1X Never Married 2☐ Married 5 Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) than Elementary/Secondary (0-12) 0 Infant other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event sons. 17. Father's Name (First, Middle, Last) Be Terri Michelle Wade William Nathan Ramey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 New Hampshire Ave NW 19a. Informant's Name/Relationship (Type, Print) William Ramey, Father Washington, DC 20010 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 11/16/05 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sen 3831 Georgia Ave NW Latney's Funeral Home Washington, DC 200 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sudden Unexplained Death in Infancy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physicien: The faw requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Completed by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year igned by the atte Month Dav 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 DNO 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No autopsy performed? 1 Ves 2□No Division of Vital After this certific funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 1 Xyes 2 □ No Pound (Month, Day Year) unk-28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Found At Attending 1 Natural 5 Pending 1 Tes 2 No investigation -1-05 2 Accident 6:00 6 Could not be 3 🗌 Suicide 28f. Location (Street and Ny 2007) Burah Route Numicourt City or Town, State) 3207 Johnson Court 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò Lanham, Maryland Found at residence To the Hospital within 24 hours a To the Funeral C 🖂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely fi Medical 20XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 2, 2005 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) My C. RIPPLA 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

| | | | For State Registrar | State | of Marylan | | artment rtificate | | | nd Me | | giene | 005 | 38 | 072 |
|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------|----------------------------------|-------------------------------------------------|----------------------|-----------------------|--------------------------|-----------------------------|-------------------------|-------------------------------|---------------------------|---------------------------|
| ı | Physici | an | 1. Decedent's Name (First, Midd. | | | | - | | | | Date of Dea | ath Day | | | ne of Death |
| | /Medic | cal | David H. V | | ımber) | | 4b. City, To | own, or Lo | cation of [| | ovembe | | 200. | | .5 PM M |
| | LAdimir | E | 6113 Bell: | • | | | | alti | | | | | | | |
| | Funeral | | 5. Social Security Number | 6. Sex 1 1 M 2 □ F | 7. Age (In yrs. | ** | If Under 1 Months (| | Under 24 Hours | Hrs. 8. Min. | Date of Birt (Month, Day | h y, Ye <i>ar)</i> | 9. B | irthplace (S. | tate or Foreign |
| н. | Director | | 020-12-8045 Usual Residence of Decedent | - X 201 | 86 | Yrs. | | | | | an 25 | | | w Jers | |
| | yiand how | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | ocation | | | | | | | 10d. Insi | de City Limits |
| : | Ba-fel | ctor | MD | | I | Baltimo | ore | | | | | | | 1X | Yes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip C | ode | | | | 10g. Citiz | en of What (| Country? | |
| | ne 23g | Funeral | 6113 Bellinhar | | 1321 cedent Ever in U | S 12 1 | Mas Dooder | | 1210 | 2 (5000) | Van as Na | - 1 | USA 4. Race - An | redeen ladie | |
| | or Hen | Fun | 1 Never Married 2√7 Mar | Armed F | orces? 2 No ive | 1 | Was Deceder If Yes, specify | | | Puerto Ric | an, etc.) | | Black, Wh | | u 1, |
| 3 | urel', c | d by | 3 ☐ Widowed 4 ☐ Divorced | | Dates: | | 1 ☐ Yes 2¶ | ZI NO . S | Specify: | | | | Specify: | white | |
| 2 | nati | Completed | (Specify only highe | nt's Education st grade completed |) | (Give | dent's Usual (kind of work of DO NOT use | done duri | in ing most o | f working | | 16b. Kir | nd of Busines | s/industry | |
| 7 | iene. | ошо | Elementary/Secondary (0-12) | | (1-4or 5+) | 1110. 1 | archit | | | | | but | ilding | 2 | |
| 2 | z should be lied within 7.2 hours after bean with the waryland and Mental Hygiene. Is marked other then "naturel", or items 23a or 28a-1 show aumatic event, it is Medical Examir at must be notified at | Be C | 17. Father's Name (First, Middle, | | Z1 | | arciiil | | l. Mother's | Name (F | irst, Middle, | | | | |
| <u>x</u> | snould b and Menti marked | To | William W | | | | | | A | Ada M | ary E | llin | | | |
| <u>ו</u> | and 2 sn ealth and m 27 is m | | 19a. Informant's Name/Relations | | | | ng Address (S | | | | | - | | | 010 |
| | ges 1 and 2 should be filled within 72 hours after death with the warylar to fleating and Mental Hygiene. If them 27 is marked other then "naturel", or iteme 23s or 28s-1 show or other traumatic event, the Medical Examinar must be multilist at | | Allen Wilson/sp 20a. Method of Disposition | ouse | 20b. P | lace of Dispo | Belli sition (Name | of | Cour | Oate | | | ation - City o | | 210 te |
| | rages nent of I int: If it | | 1 ☐ Burial 2 ☐ Cremation 1 ☐ Burial 2 ☐ Cremation | | State | emetery, crer | natory or othe | er place) | | | | | , | | |
| | permit. Pages 1 and 2 Department of Health a Important: if item 27 is eny injury or other tra once. | | 21. Signature of Euneral Service Ronald | | Director | r Si | Name and | Address | Eachity Bo | ard 6 | 555 W. | Ba1 | timore | Stre | et |
| | 8979 | | /man | 4/1// | gee_ | Ва | altimo: | re, M | D 2 | 1201 | | | | , | |
| F | hysician /Medical | | 23a. Palt 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | a | each line. | T. VE | | | | | | | | | Between and Death |
| E | xaminer | | Conventially list conditions | b | (or as a conseq | uence or. | | | | | | | | | |
| | 3 13 | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | (or as a conseq | uence of): | | | | | | | | | |
| | and and al-trans | Examiner | that initiated events resulting in death) Last | (or as a conseq | nsequence of): | | | | | | | | | | |
| 5 | physician and s the burial-transit | dicai E | | l d | , | | | | | | | | | | |
| 9 | ng phy as th | Medi | 15.55141.5 | | | | | | | | | | | | ~~~ |
| 5 | inal ine deals certificated by the attending properties as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 1 Live | itcome of pregna birth 2 ☐ Feta | death 3 | Ectopic preg | nancy | | | | 2 | 3d. Date of d | | Vees |
| 5 | the a | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4∐Preg 9□ Unki | nant at time of di nown | eath 5□ | Other (spec | rfy) | | | | İ | MOUIII | Day | Year |
| | signed by | by Ph | Part II. Other significant conditi | ons contributing to | death but not res | ulting in the u | nderlying cau: | se given ir | n Part I. | | 23e. Did to | bacco us | e contribute | to the cause | of death? |
| <u>.</u> | en sig | ed t | EMPHYSET | AC | | | | | | | 1 X Y | 'es 2□ |]No 3 ☐ F | robably | Unknown |
| ر د را | as be | Completed | DODI | | | | | | | | 24a. Was a | | | | ngs available of cause of |
| | cate l | | | | | | | | | | perfor | | death? 1 ☐ Ye | | |
| 5 | s certificacto | To Be | 25. Was case referred to medica examiner? 1 ☐ Yes 2 ▼No | Hospital | Inpatient 2 🗆 | ER/Outpatien | t 3 DOA | Other | | | heck only or | | 70 | | |
| 5 8 | griny ter this neral c | | 27. Manner of Death | 28a. Date | of Injury | 28b. Time of Injury | | . Injury at Work? | 4 🗌 Nursii | | . Describe h | | Other (Sp | ecity) | |
| 5 | eath. lor: Al | catic | 1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could | gation | , , , , , , | | М | | 2 🗆 No | | | | | | |
| | after d Direct | Certification: | 4 Homicide determ | nined 286. Plac | e of Injury - At ho ling, etc. (Specify | ome, farm, str y) | eet, factory, o | office | | 28f. | Location (S City or Tow | itreet and n, State) | Number or F | Rural Route | Number, |
| | To the hospital or Attending Frigstoner: The tay requires that beant certificate be executed within 24 before late death. To the Functor birectors After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical C | 29a. Certifier (Check only one) 1 Certifyin 2 Medicel | ng Physician: To th Examiner: On the and mai | e best of my kno pasis of examina nner stated. | wledge, death tion and/or inv | n occurred at vestigation, in | the time, o | date and pon, death o | olace, and occurred : | due to the cat the time, c | ause(s) a | and manner a place, and du | s stated. e to the cau | se(s) |
| 1 | withir To th comp | Me | 29b. Signature and little of certifie | 1 | · | | 29c. L | icense nu | ımber | | 2 | 29d. Date | signed (Mor | th, Day, Ye | ar) |
| | | | P 41113 | La n | NO | | 0 | 445 | 60 | | 17 | ill | rloi | | |
| | | | 30. Name and address of person | who completed cau | se of death (Item | 23а) (Туре, | Print) Su | ITE | | | | | irloi 6 an | | |
| | Sta | te | 31. Date filed (Month, Day, Year, | 321 | 1005.57 Registrar's Signa | ture & | ENHS | - OR | | TO | 2501 | 2 | N179 | 1304 | |
| | Registr | | NOV 2. 8 | 2005 | 1643 N 13 | 600 | age! | | | | | | | | |

| | | | 1 - State Amend Item 20 | State of Marc&22 pe | aryland / Department of the control | artment of H rtificate of I | lealth and Death | Mental Hyg | iene 005 | 38073 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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| 18 | Physici | 20 | 1. Decedent's Name (First, Middle, Last |) | | | | 2. Date of Deat | h Day / Year | 3. Time of Death |
| | Physici /Medi | | Geraldine Waller | | | | | NOVEMBE | R14,200 | 05 18:17 M |
|) | Examir | ner | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, or | r Location of Dea | ath | 4c. County of Dea | ith |
| T. | | 1.0 | SITINI HUN | BS 110. | SPITAL | BAL | TOMOR | | | |
| | Funeral Director | | 212-40-3321 | X 7. Ag | e (In yrs. last birthday) 55 Yrs. | If Under 1 Year Months Days | If Under 24 H | | 1950 Mar | rthplace (State or Foreign ountry) yland |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | aho | 5 | , | | | | | | | 1⊕Yes 2□No |
| | 28a- | Director | MD 10e, Street and Number | | Baltim | 10f. Zip Code | | 11 | og. Citizen of What C | Λ |
| | with be or | ā | 3330 Wilkens Ave | niie | | | 229 | | US | • |
| | ns 23 | era | 11. Marital Status | 12. Was Decedent | Ever in U.S. 13. | | | (Specify Yes or No- | 14. Race - Am | |
| 21215-0036 | d within 72 hours after death with the Maryland jiene. r than "natural", or Itama 23a or 28a-1 show The Madical Examinar must be notified at | by Funeral | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: | No | If Yes, specify Cuba 1 ☐ Yes 2 No | Specify: | erto Rican, etc.) | Black, Whi | |
| ğ | 2 hou | pel | 15. Decedent's Edu | cation | 16a. Dece | dent's Usual Occup | ation | | 16b. Kind of Business | s/Industry |
| 7 | c * # | Completed | (Specify only highest grad | le completed) College (1-4or: | life. | kind of work done of DO NOT use retired | during most of w d) | rorking | | · |
| 5 | filed with Hygiene. ther ther | E O | 12 | 0 | 517 | bus drive | er | | transport | ation |
| | s t and 2 should be filed within f Health and Mental Hygiene. Item 27 ie marked other then other traumatic event, Ins M. | Be | 17. Father's Name (First, Middle, Last) | | | unk | 18. Mother's N | ame (First, Middle, A | Maiden Sumame) | |
| <u>8</u> | Mentai Merksd o natic evs | ToE | | | | | Thelm | a Thomas | | |
| Maryland | and has is ma | | 19a. Informant's Name/Relationship (T) | /pe, Print) | 19b. Maili | ng Address (Street | and Number or | Rural Route Number, | City or Town, State, | Zip Code) |
| | t and 2 Health 1sm 27 other tra | | Myron Jackson/son | | 58 S | tevens Fo | rest Roa | ad Columbi | a, MD 2104 | 45 |
| Baltimore, | | | 20a. Method of Disposition | Samuel from Chata | 20b. Place of Dispe | osition (Name of matory or other place | | | 20c. Location - City or | |
| Ĕ | | | 1 ☐ Burial 2 MT Cremation 3 ☐ F 4 ☐ Donation 5 MT Super (Specify) | in state | Green Mou | nt Cremate | ory 11-2 | 28-05 B | alto., Md | |
| = | permit. Page Department of Important: if any injury or once. | | 21. Signature of Fundral Spaces Licens | 00 / 1/ | 2 | 2. Name and Addre | ss of Facility Ca | alvin B. S | cruggs Fur | |
| 0 | Deg de | | Monard J | Narde / V | | | | | Baltimore Preston S | Street L. Balto. 1 |
| | Cate be executed Medical Examiner interpretation Cate be executed Cate be execu | Examiner | Immediate Ca\se (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Human Due to (or as | a consequence of): a consequence of): a consequence of): | red In | muul | Deficia | ing | Onset and Death Uliu |
| | The law requires that the death certificate bevate has been signed by the ettending physicien age 2 should be detached for use as the burn | Physician/Medical I | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | d | 2 Fetal death 3 | □Ectopic pregnancy □ Other (specify) _ | · | | 23d. Date of de Month | olivery Day Year |
| rds, P | w requires that been signed b should be deta | þ | Part II. Other significant conditions co | | out not resulting in the c | | ren in Part I. | | acco use contribute to | o the cause of death? |
| of Vital Records, | The law requirate has been page 2 should | Completed | , | | | | | 24a. Was an autops perform | y prior to death? | utopsy findings available completion of cause of |
| ā | ilcian: Th certificate rector, pag | Be C | 25. Was case referred to medical | | | | 26. Place of D | eath (Check only on | | |
| > | S S E | 70 | examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) | Hospital: 1 ☐ Inpati | ent 2 ER/Outpatie | nt 3 DOA Oth | er: 4 Nursing | Home 5 ☐ Reside | nce 6 Other (Spe | ecify) |
| o uo | nding Phi ath. r: After thi e funeral | | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Inju (Month, Da | ury 28b. Time of Injury | Wor | y at k? Yes 2 □ No | 28d. Describe ho | w injury occurred | |
| Division | al or Atte after de i Directo d in by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of In building, e | jury - At home, farm, st cc. (Specify) | reet, factory, office | | 28f. Location (St. City or Town | reet and Number or R , State) | tural Route Number, |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical C | 29a. Certifying Phy (Check only one) | rsician: To the best iner: On the basis of and manner st | of my knowledge, deal of examination and/or in lated. | th occurred at the tire to the | me, date and pla pinion, death oc | ce, and due to the ca curred at the time, da | use(s) and manner a ate and place, and du | s stated. e to the cause(s) |
| | To th Mithin To th compl | Me | 29b. Signatur and title of certifier | # NO 19 | | 29c. Licens | | | d. Date signed (Mon | |
| | ->-0 | | Kettune 1x | W | | 7) 3 | 35543 | 1 | Tovanher | 14, 2005 |
| | | | 30. Name and address of person who co | ompleted cause of a | death (Item 23a) (Type | Print) A | 2m1 2 | But time | 18 Uldan | 14, 2005 - land 21229 |
| | 4 3 W C+ | ate | 31. Date filed (Month, Day, Year) | 32 Regist | 900 Co | 100 / / / | · · · · · · · · | / | 100000 | |
| (A) - | Regist | | NOV 2 8 20 | J5 12 164 | S 15 100 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rita Lennell White 10 wiember 19 බුගත /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/AGenera KKY Ospita' laga If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Day, Year) 1956N. Country) 18,1956N. Carolina Months Days Hours 1 ☐ M 2√2 F 49 218-64-2143 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State rei', or Items 23e or 28e-f show Examiner must be notified at X Yes 2 No Baltimore N/AMaryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 USA 819 Newington Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of death and Mental Hyglene. Im 27 le marked other then "neturel", or Iter Armed Forces? 1 ☐ Yes — Q No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Human Resources 11th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willie Thelma Wilson Garnett Barnes 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 819 Newington Ave Baltimore, Maryland 21217 permit, Pages 1 and 2: Department of Health ar Importent: If item 27 le eny injury or other treugnce. Ayris Barnes/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-28 & Woodlawn, Maryland King Memorial Park *4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facilit Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Paneral Service 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impodiate Cause (Final 10 10 Diabetes mellitus with Pnysician resulting in death) /Medical Due to (or as a consequence of): Examiner astrointes tind 9 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to for as a consequence off Examiner 3 Yun certificate be executed use as the burial-transit eripheral Vasalar albean that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ØYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No this certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending 2 🗌 No death. 1 Tes investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide ō within 24 hours a To the Funerel C Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

P.O. Box 68760.

Division of Vital Records.

State Registrar 31. Date filed (Month, Day, Year)

m. en - Down

82

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Rm 206

Gutter street 32. Bigistrar's Signature

inp

29c. License number

Baetimore

031801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per ft 9849 11-28-05 yt.
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) WARREN NOVENBER 21 6:15 AM **Physician** GENE VIEVE 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore GENESIS HOMEWOOD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** 1 □ M ¾□ F Yrs Maryland 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ehow r than "natural", or Items 23a or 28e-f ehov the Medical Every are must be notified at 1¥ Yes 2 No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21212 514 East Coldspring Lane Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: Black þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Pikesville Nursing Home College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene, Importent: If Item 27 is marked other than any Injury or other treumatic event, Item and Since. Nursing 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Florence Young Richard Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 514 East Coldspring Lane Baltimore, Maryland 21212 Francis Fraling Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 11/23/05 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 23a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

EMENT A disease or condition resulting in death)

a. EMENT A 21. Signature of Funeral Service Licenses Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTELY DISEASE 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 🖼 €nknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy page 2 performed? 2 No 1 Yes 2 1 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 ₽Mo Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred the funeral 28b. Time of 27 Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined filled in by 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) & Specker

Awuch

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

LORRAINE OFOR-AWUAH, 5601 LUCH RAVEN BLVA. BALTIMORE, NO 21239

D 0061789

NOVEMBER 22, 2005

| | | | For Stata Ragistrar | State of Marylan | • | rtment of F | | ntal Hygien | 2000 | 38076 |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------|--------------------------------------|---------------------|---------------------------------|
| | 0 | | Decedent's Name (First, Middle, Las | 0) | ^ | | | Date of Death | | 3. Time of Death |
| | Physicia | | JOSEPH FR | 1 CALINIA | NE G | MAN | Sc. N | Nonth | 22, 200 | 5 3:30 PM |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | street and number) | 701-1 | | r Location of Death | | c. County of Deat | |
| | LXaitiiii | Ψ. | 3722 GRE | CHIVALE | Rd. | Bal | timore | I | Baltimo: | re County |
| | Funeral | | 5. Social Security Number 6. Se | 7. Age (In yrs. | last birthday) | If Under 1 Year Months Days | | Date of Birth | Q Riet | hplace (State or Foreign untry) |
| | Director | | 220-24-6416 | ² | Yrs. | Widitiis Days | Tiodis Witt. | (Month, Day, Yea 09/27/1 | 929 Ma | ryland |
| | pu » | | Usual Residence of Decedent 10a. State 10b. County | 10c Cit | y, Town or Loc | cation | | | | 10d. Inside City Limits |
| | shov | 2 | | | | | | | | 1⊠ Yes 2 □ No |
| | he M 28a-1 | Director | MD Baltir 10e. Street and Number | iore B | altim | 10f. Zip Code | | 100.0 | citizen of What Co | unto/2 |
| | a or | ă | | Dood | | | 0 | | | |
| | eath | era | 3722 Greenvale | 12. Was Decedent Ever in U. | .S. 13. V | 2122 Vas Decedent of h | Hispanic Origin? (Specif | | ited Si | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show shi righty or other traumatic event, the Midfield Examinational be notified at once. | by Funeral | 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced | Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: | 11 | Yes, specify Cub | an, Mexican, Puerto Ric Specify: | an, etc.) | Black, White | |
| 21215-0036 | 2 hou | | 15. Decedent's Ed | ucation | | ent's Usual Occup | | 16b. | Kind of Business/ | Industry |
| 212 | nin 7. | Completed | (Specify only highest gra | de completed) College (1-4or 5+) | (Give | kind of work done DO NOT use retire | during most of working d) | | | |
| 21 | d with giene ar tha | No. | 12 | | Asse | mbly - | General M | iotors | Motor 2 | Assembly |
| | al Hy l othe vent, | Be (| 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Name (F | First, Middle, Maide | en Sumame) | |
| <u>/a</u> | Ment Ment arked | 70 | Edward Weigman | | | | Marie | Geisler | | |
| Maryland | 2 shc and Is ma | | 19a. Informant's Name/Relationship (7 | • | | | and Number or Rural R | | | |
| | and lealth m 27 her tr | | Dorothy M. Weig | | _ | 2 Green sition (Name of | vale Rd., | | | |
| Ore | ges 1 t of H If ite or ot | | 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ | Romoval from State | emetery, cren | natory`or other pla | ce) | | Location - City or | |
| ij | t. Pa tmen tant: ijury | | `A □ Donation 5 □ Other (Specify | | edar : | | 1 | 6/2005 | - | |
| Baltimore, | Depar Impor any ir | | 21. Signature of Funeral Service Lisen | Lind | H 4 | ubbard 107 Wil | ss of Facility Funeral H kens Aven | ome, Ir ue, Bal | c. timore | MD. 21229 |
| | | | 23a. Part1. Phter the disease, or company shock, or heart failure. List only | olications that caused the deat one cause on each line. | h. Do not ente | er the mode of dyi | ng, such as cardiac or re | espiratory arrest, | , | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Cer | ebr | OVASA | ULAR | Accid | tog | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a conseq | | | | 1_1 | | · y |
| | Examiner | | Sequentially list conditions | b | | | | | | |
| | pe iis | Examiner | if any, leading to immediate cause. Enter Underlying | Due to (or as a conseq | uence of): | | | | | |
| | and I-tran | хаш | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a conseq | mence of): | | | | | |
| 8760, | cate be executed physician and the burial-transit | | | 220 (0. 00 0 00.000) | 3.7. | | | | | |
| 387 | phys the | dlcal | | . d | · · · · · · · · · · · · · · · · · · · | | | | | |
| × | death certific e attending p nd for use as | Physician/Me | IF FEMALE: | 23c. If yes, outcome of pregna | ancy | | | | 23d. Date of del | ivery |
| Вох | atter for u | ciar | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d | Ideath 3 | Ectopic pregnanc Other (specify) | у | | Month | Day Year |
| 0 | 0 0 | lsk | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | | | | | |
| σ. | res that the signed by th be detache | by Pt | Part II. Other significant conditions of | ontributing to death but not res | ulting in the u | nderlying cause gr | ven in Part I. | 23e. Did tobacco | o use contribute to | the cause of death? |
| rds, | requires been sign bould be | | | | | | | 1 🗆 Yes | 2 ⊠ No 3□Pr | obably 4 Unknown |
| Record | > 40 0 | ompleted | | | | | | 24a. Was an | 24b. Were au | topsy findings available |
| Re | 0 - 0 | E O | | | | | | autopsy performed? 1 ☐ Yes 2 🔀 | death? | completion of cause of |
| Vital | ian: The rtificate stor, pag | e C | 25. Was case referred to medical | | | | 26. Place of Death (0 | | 40 103 | 20110 |
| <u></u> | ysic is ce direc | O B | examiner? 1 Tes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatien | t 3 DOA Ott | ner: 4 Nursing Home | 5 Residence | 6 □Other (Spe | cify) |
| οľ | | n: T | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Inju Wo | | d. Describe how in | jury occurred | |
| ior | Attending For death. ector: After by the funer | atlo | Natural 5 Pending investigation | | ,, | | Yes 2□No | | | |
| Division | | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Specif | ome, farm, str | eet, factory, office | 281 | Location (Street City or Town, Sta | | iral Route Number, |
| | ital or urs afte ral Dii | | | | | | | | | |
| | To the Hospital of within 24 hours at To the Funeral D completely filled it | edicai | | ysician: To the best of my kno ninar: On the basis of examina and manner stated. | | | | | | |
| | To the Hc within 24 I To the Fu completely | ž | 29b. Signature and title of certifier |) | | 29c. Licens | | | Date signed (Monti | h, Day, Year) |
|) | , | | 1 com H | a . | mo | DO | 055033 | 5 11 | 123/0 | 5 |
| h | 114 | | 30. Name and address of person who | completed cause of death (Iter | m 23a) (Type, | Print) | 01 | 10 | (1. | Im O |
| 9 | | | Lynn Hallan | an MD 3 | 3900 | hach k | Reven Bl. | M. Dec | (Timore | mD21218 |
| • | Sta Regist | | 31. Date filed (Month, Day, Year) | 32. Segistrar's Signa | ature | mes | | • | | |
| | negist | all | I NUV & X 4 | And the state of the state of | The state of the s | | | | | |

| | | | For State Registrar | State of | Maryland | | ment of H | | d Menta | 1) | 005 | 20077 |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------|------------------|-----------------------------------|-----------------------------------------|--------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| | 78 | 10 Table | Registrar 1. Decedent's Name (First, Mide | dle. Last) | | Certin | Cale Of L | Jeani | 2. Date | Reg. No. | 000 | 3. Time of Death |
| * | Physici /Medic | an | Charles (| BilBerT | | | | | Mon | 11-18- | 0.5 | 174184 |
| 1. | Examin | er | 4a. Facility Name (If not instituti | | | 4b | . City, Town, or | ~ · · · · · · · · · · · · · · · · · · · | eath C | 4c. | County of Death | |
| | Funeral | 1947 | 5. Social Security Number | | OSDITAL . Age (In yrs. last | | Under 1 Year | If Under 24 H | Irs. 8. Date | of Birth | 9. Birtho | lace (State or Foreign |
| 120 | Director | | 215-86-4318 | 12M 2□F | 34 | Yrs. Mo | onths Days | Hours M | in. JA | nth, Day, Year) | Cour | MD |
| | and | - | Usual Residence of Decedent 10a. State 10b. Count | sy . | 10c. City, T | own or Location | on | | | | 1 | Od. Inside City Limits |
| | Maryl -f sho | tor | MD | | B | ALTIM | 088 | | | | | 1 Yes 2 □ No |
| | or 28a | Funeral Director | 10e. Street and Number | | | | Of. Zip Code | | | 10g. Citi | zen of What Cour | ntry? |
| | ath wi | rai | | JAN AVE. | | | | 1218 | | | U.S.A. | - India |
| | Items | nne | 11. Marital Status 1 ☐ Never Married 2 ☑ Ma | Armed Ford | | 13. Was | Decedent of Hi s, specify Cuba | spanic Origin? n, Mexican, Pu | (Specify Yes ierto Rican, e | s or No- | 14. Race - Americ Black, White, | |
| 036 | al', or | þ | 3 Widowed 4 Divorce | If Yes, Give | | 1 🗆 ' | Yes 2 No | Specify: | | | Specify: BIA | cK. |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "natural", or liema 23a or 28a-f show ha Madigal Examiner must be notified at | Completed | | ent's Education lest grade completed) | 1 | (Give kind | s Usual Occupa of work done | turing most of | working | 16b. Ki | nd of Business/In | dustry |
| 121 | withir ene. then | dwc | Elementary/Secondary (0-12) | College (1- | 4or 5+) | me. DO | DIS A | | | | | |
| | be filed tal Hygi d other avent, I | Bec | 17. Father's Name (First, Middle | | | | | | Name (First, | Middle, Maiden | Sumame) | |
| ylaı | 2 should be filed withing and Mental Hygiene. Is marked other than surnatic avent, the Mental Cavent, the Mental Cavent C | T0 | 1 1 10 0 | BerT WA | | | | | Y JBU | | intyre | |
| Maryland | d 2 sh th and th and 7 ta m traum | | 19a. Informant's Name/Relation | nship (Type, Print) Wtyne Uw | 0. | 196. Mailing Ai | | | | Number, City o | r Town, State, Zip | (Code) |
| | s 1 and f Health item 27 other tr | | 20a. Method of Deposition | 9 | com | e of Dispositio | | | Date | | cation - City or To | own, State |
| E | Pages nent of I int: If its ury or o | | 1 ⊠Burial 2 □ Cremation 4 □ Donation 5 □ Other | | tate | TONO | MCI. | 11. | -26-0 | 5 BA | rlto. MD |), |
| Baltimore, | permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or itema 23a or 28a-f show any injury or other traumatic avent, the Madical Examinat must be notified at ance. | | 21. Signature of Funeral Service | 1. 0 | | 22. Na | me and Address | is of Facility | un Sv | P.A. | 15 | 0 |
| | 005 e d | Н | 23a Part Foter the disease | Seguer or complications that ca | used the death. I | Do not enter th | Apel: 33 | 572 Fre | Decic | AJE. E | Alte. MI | Approximate |
| 7 | Physician | | 23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final | | EMON | | , | •• | | , | | Interval Between Onset and Death |
| 15. | /Medical | | disease or condition resulting in death) | a | or as a consequen | | | | | | | |
| ** | Examiner | | Sequentially list conditions, if any, leading to immediate | b | or as a consequen | on of): | | | | | | |
| V | petr I Insit | Examiner | Cause (Disease or injury | \ | as a consequen | 100 01). | | | | | | |
| oʻ | exect en and irial-tra | | that initiated events resulting in death) Last | CDue to (c | or as a consequen | nce of): | | | | | | |
| 8760 | cate be ohysici the bu | dical | | d | | | | | | | | |
| Box 68 | certific Iding p | /Me | IF FEMALE: 23b. Was decedent pregnant | | ome of pregnancy | | | | | | 23d. Date of delive | erv |
| | Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit | Physician/Med | in the past 12 months? 1 ☐ Yes 2 ☐ No | | rth 2 ☐ Fetal de unt at time of deat wn | | opic pregnancy ner (specify) | | | | Month | Day Year |
| P.0 | het the d by ti | Phy | 9 ☐ Unknown Part II. Dther significant condi | | | ng in the under | tving cause give | an in Part I | 236 | a. Did tobacco u | se contribute to t | ne cause of death? |
| Records, | uires t signe | d by | | | | | ,,,,g occor g | | | 1 ☐ Yes 2 | | 1. |
| OS | aw requir is been si 2 should | Completed | | | | | | | 248 | a. Was an autopsy | 24b. Were auto | psy findings available mpletion of cause of |
| <u>R</u> | The late happened | Com | | | | | | | 1 🗆 | performed? Yes 2000 | death? | 2□ No |
| Vital | ician: Sertific ector, | Be | 25. Was case referred to media examiner? | Hospital: | | | 3D DOA Othe | 26. Place of I | | | | |
| of | Phys r this ral dir | : To | 1 ☐ Yes 2 No 27. Manner of Death | 1 | | VOutpatient 3 | 28c. Injury Work | 7 11013 | | Residence scribe how injur | 5 ☐Other (Specification of the second of th | y) |
| ion | Attending r death. ector: After by the fune | atior | 1 Natural 5 ☐ Pend 2 ☐ Accident inve | ding (Month stigation | n, Day Year) | Injury | | k? Yes 2 □ No | | | | |
| Division | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certification: | 3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete | mined 289. Place | of Injury - At home g, etc. (Specify) | e, farm, street, | factory, office | | 28f. Loc City | ation (Street an or Town, State | d Number or Rura) | al Route Number, |
| | Hospital of hours a Funerel D | aj Ce | 29a. Certifier 12 Certif | ying Physician: To the | best of my knowle | edge, death oc | curred at the tim | ne. date and pl | ace, and due | to the cause(s) | and manner as s | tated |
| | the Hounin 24 h the Fur hpletely | Medical | (Check only 2 Medic one) | al Examiner: On the ba and mann | sis of examination | and/or invest | igation, in my of | pinion, death o | ccurred at the | e time, date and | place, and due to | the cause(s) |
| | Withi To t | Σ | 29b. Signature and title of certi | | | | 29c. License | | | | e signed (Month, | |
| | | | PVS | mb | | | | 8463 | | No | V 18, 20 | 005. |
| | } | | 30. Name and address of person | | of death (Item 2: | | ii) There | | 2175 | 2.1 | | |
| 44 | Sta | ate | 31. Date filed (Month, Day, Ye. | ar) 32 A | gistrar's Signatur | | A I | 1.000 | 210 | , | | |
| | Regist | rar | NOV 2 | 8 2005 | gran St | 13004 | | | | | | |

The law requires that the death certificate be executed attending physician Hospital or Attending Physician: after death Diractor: 24 hours a within 2

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

ō

filed within 72 hours after death

d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked othar than "r

Pages 1 and 2 s ment of Health an Department of Health a Important: If itam 27 Is any injury or other train once.

Physician

Baltimore, Maryland 21215-0036

traumatic evant, the Medical Examiner must be notified at

Completed by Funeral Director

Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 25. Was case referred to medical examiner? Certification: To 27. Manner of Death 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier November 24,2005

Registrar

31. Date filed (Month, Day, Year)

ABDALLAH J.

HELOU, M.D.

me and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 28 2005 32. Registral's Signature

CARROLL HOSPITAL

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examiner must be applified at once. Baltimore, Maryland 21215-0036

Physici /Media Examir

Funeral Director

For State

Physician

| | Exa | miner | |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| Ŕ | | | ă |
| Division of Vital Records, P.O. Box 68760, | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death | To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical Certification; To Be Completed by Physician/Medical Examiner |
| | | X | -1 |

| | - negistrar | | | | | | | 0111 | nout | 10 07 1 | Journ. | | | Hag. r | 10. | | | |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------|---------------------------------|--------------------|---------------------|--------------------------|------------------|-----------------------------------------|--------------------------|--------------------------|-----------------------|-----------------------------------|--------------------------------|---------------------|---------------------|------------------------------|-------------------------------|
| an | Decedent's Name BEATRICE | | | | | | | | | | | | 2. Date of I Month NOVEM | | ay 3RD. | Year 2.00 | | me of Death |
| al | 4a. Facility Name (/ | | | | ımber) | | | 4 | th. City. | , Town, or | Location | of Death | | | c. County | | | .0.72 |
| er | | | - | | , | | | | , | | | | | | | | | |
| | MEMORIAL | | | | 1 - 1 | | | | | <u> BERLA</u> | | - 04 Usa | 1 | | ALLEC | | | |
| | 5. Social Security N | lumber | 6. Se | | 7. Age | (In yrs. I | last birthda | -,, | onths | Days | Hours | r 24 Hrs. Min. | 8. Date of I | Birth Day, Yea | ır) | 9. Birth | nplace (S u <i>ntr</i> y) | tate or Foreign |
| | 232-48-3 | 204 | 11, | ⊒M 2∏ F | - | 73 | Yrs | . [| *************************************** | 54,0 | | | 08/29/1 | - | , | | Virg | inio |
| | Usual Residence of | | | | | | | | | | | - | 1001221 | 7.72 | | MESE | ATTR | IIIIa |
| | 10a. State | 10b. County | у | | | 10c. City | y, Town or | r Loca | tion | | | | | | | | 10d. Insi | ide City Limits |
| ŏ | wv | Destano | | | | | D. | | | | | | | | | 1 | 1 | Yes 2√No |
| ct | WV | Putna | UN | | | | P(| oca | | | | | | , | | | | X |
| E E | 10e. Street and Nur | mber | | | | | | 1 | 10f. Zij | p Code | | | | 10g. (| Citizen of | What Co | untry? | |
| | τ | 0. Box | . 128 | 2 | | | | | | 2 | 5159 | | | | USA | | | |
| era | 11. Marital Status | •0• DOX | 120 | 12. Was Dec | edent S | ever in 11 | S 1 | 3 W= | as Daco | | | rigin? (Sr | pecify Yes or | No- | 1 | ce - Ame | rican Indi | an · |
| 5 | | | | Armed F | orces? | | ٠. ا | If Y | es, spe | ecify Cuba | in, Mexica | n, Puerto | Rican, etc.) | 140- | | ck, White | | w, |
| F | 1 Never Marri | | | 1 ☐ Yes If Yes, G | 2 X N | lo | 1 | 1. | Yes | 2X) No | Specify | <i>,</i> - | | | Specif | he- | | |
| 9 | 3 □Widowed | 4 Divorce | d | Year or [| Dates: | | | | •• | 2,4,0 | Ороспу | | | | Specif | | ite | |
| Be Completed by Funeral Director | | 15. Decede | nt's Ed | ucation | | | 16a. De | eceder | nt's Usu | al Occup | ation | | | 16b. | Kind of B | usiness/ | ndustry | |
| oje | | | est grad | de completed, | | | (G | ive kii e. DC | nd of wo NOT u | ork done d | du <i>ring</i> mo: () | st of worl | king | | | | | |
| Ē | Elementary/Seco | | | College (| 1-4or 5 | +) | , | т. | | | | | | | | | | |
| ပိ | | | 1 000) | | | | 1 | iome | make | er | 40.11-45 | - 4- NI- | - 071 A41-4 | d- 84-:- | | naker | | |
| Be | 17. Father's Name | (FIISL, MIUUI U | , Last) | | | | | | | | 10. MOUI | iers Nam | ne (First, Midd | ne, maio | en Sumai | пе) | | |
| ဥ | Opie | | Bro | oks | | He | rshber | ger | | | Vir | ma | Lu | cille | | Samo | es | |
| | 19a. Informant's Na | ame/Relation | ship (T | ype, Print) | | | 19b. M | ailing | Addres | s (Street | and Numb | er or Ru | ral Route Nun | ber, City | y or Town | | | 1 |
| | Donald Atk | incon / | huel | hand | | | D C |) D | . 1 | 20 D | | . 527 | | | 220 | | | |
| | The second secon | | nus | Danu | | 20h B | P.C lace of Di |). B | OX 1 | 28, P | oca, w | lest V | /irginia Date | | | 011 | | |
| | 20a. Method of Disp 1 ☑ Burial 2 | | 3 □ | Removal from | State | | emetery, | | | | (e) | | Dale | 200. | Location | - City or | rown, Sta | 16 |
| | 4 Donation | | | | · Olulo | Gran | ndview | , Мо | mori | ol Dos | -1- | 11/00 | /2005 | The | | ** | 17. | |
| | 21. Signatur of Fu | eral Service | Licens | see / | | Orth | and vick | | | nd Addres | ss of Facil | | 3/2005 | | | | | |
| | 1/1 | 211 | 7 | 1.1. | | | | | | | | Ac | lams Fam | | | | e, P.A | 1. |
| | res | ur C | | vae | | | | | | | | | Cumberla | | D_21° | 502 | | |
| | 23a. Part1. Enter t shock, or hea | he disease, d irt failure. Lis | or comp st only c | one cause on | caused each lir | the death ie. | h. Do not | enter | the mo | de of dyin | g, such as | s cardiac | or respiratory | r arrest, | | | Interv | ximate al Between |
| | Immediate Cause | | | TED A C | ומודים | רנו מק | דו עד | mii | MET | TOAT | COM | DT TO | AMTONG | | | | | and Death |
| | disease or condition resulting in death) | л | - | | | | LP WI uence of): | | MEL | TUAL | COM | | ATIONS | | | | 1 1/ | 2 DAYS |
| | | | | 00010 | (OI as | a consequ | derice or). | | | | | | | | | | | |
| | Sequentially list co | nditions, | | b | | | | | | | | | | | | | | |
| ne | if any, leading to in cause. Enter Under | erlying | , | Due to | (or as | a consequ | uence of): | | | | | | | | | | | |
| E | Cause (Disease or that initiated events | injurý s | | C | | | | | | | | | | | | | | |
| X | resulting in death) | | | Due to | (or as | a consequ | uence of): | | | | | | | | | | | |
| <u>a</u> | | | | | | | | | | | | | | | | | | |
| an/Medical Examiner | | | - | d | | | | | | | | | | | | | | |
| Me | IF FEMALE: | | | | | | | | | | | | _ | | | | | |
| an | 23b. Was deceden | | | 23c. If yes, ou 1☐Live | utcome birth | of pregna 2 Feta | incy I death | 3□£ | ctopic p | oregnancy | | | | | | ate of deli | | W |
| 0 | in the past 12 1 Tes 2 | | | 4□Preg | ınant at | time of de | | | Other (s | | | | | - | M | onth | Day | Year |
| ys | 9 Unknown | | | 9□ Unkr | nown | | | | | | | | | | | | | |
| Completed by Physici | Part II. Dther signif | ficant condit | ions co | ontributing to | death b | ut not res | ulting in th | e und | erlying | cause giv | en in Part | 1. | 23e. Di | d tobacc | o use con | tribute to | the caus | e of death? |
| p | HYPERTEN | KOTON | DΤΔ | RETES | | | | | | | | | 11 | TYPE | 2 🗆 No | 3 □ Pri | obably | 4 XUnknown |
| tec | TITE DICTOR | DION | DIII | питио | | | | | | | | | | | | | | |
| D D | | | | | | | | | | | | | 24a. W | | 24b. | Were au | topsy find | dings available n of cause of |
| E | | | | | | | | | | | | | pe | topsy rformed | | death? | | |
| Ŏ | 05 Was | | -1 | | | | | | | | | | 1 ☐ Ye | | No | 1 U Yes | 2 🗆 N | 0 |
| Be | 25. Was case refer examiner? | rea to medic | - | Hospital: | | | | - | | 0+ | | e of Dea | th (Check on | y one) | | | | |
| 2 | 1 X Yes 2 □ | | | 1 🕰 | Inpatie | | ER/Outpa | | 3 🗆 D | OA Oth | 4 □ N | lursing H | ome 5□R | esidence | 6 □Otl | her (Spec | cify) | |
| ü | 27. Manner of Deal | th 5 □ Pend | ina | 28a. Date (Mo | of Injui | ry v Year) | 28b. Tim Inju | | | 28c. Injun World | y at k? | | 28d. Describ | e how in | jury occu | rred | | |
| atle | 2 Accident | | tigation | | | | 12: | - | М | | Yes 25 | No | PATI | ו ידאק | TTTT | АТ Н | OME | |
| ======================================= | 3 Suicide | 6 Could | d not be | 28e. Plac | e of Inju | ury - At ho | ome, farm | | t, factor | rv. office | | | 28f. Location | (Street | and Num | | | Number, |
| Certification: | 4 🗌 Homicide | 20101 | u | build | ding, etc | c. (Specify | y) | | | J | • | | City or | Town, St | ate) | | | • |
| Ö | 200 (7-14) | 100 | i= | 1 | | | ESIDE | | | | | | NEW (| | | | | |
| Medical | 29a. Certifier (Check only | 1 ☐ Certify 2 Medica | ing Phy Il Exam | ysician: To th ninar: On the | basis of | examina | wiedge, d ition and/o | eath o | occurred stigation | at the tin n, in my o | ne, date a pinion, de | nd place. ath occu | , and due to t rred at the tim | ne cause ie, dat <i>e</i> a | (s) and mand place. | anner as and due | stated. to the ca | iuse(s) |
| led | one) | | | and ma | nner ste | ated. | | | | | | | | 1 | | | | |
| 2 | 29b. Signature and | title of certifi | ier | / | | | | | 29 | 9c. Licens | e number | | | 29d. I | Date signe | ed (Mont) | n, Dey, Y | ear) |
| | X1 | Eul. | _ | 1 | | | | | İ | | D0915 | 5.7 | | MOI | VEMBE | תוב קי | י ח | 005 |
| | 30. Name and add | ress of perso | n who r | completed car | ise of d | eath (Item | 1 23a) (Tu | pe Pr | rint) | | DUJI. | , , | | INO. | v THIDE | 'IV)K | ∠ و∪ | .003 |
| | | PO.30 | | | | (1101) | / \ ' ' | L-1 | | | | | | | | | | |

31. Date filed (Month, Day, Year) NOV 0 7 2005

nas

State Registrar SNOW, PAUL, M.D., DEPUTY MEDICAL EXAMINER, 124 WEST THIRD STREET, CUMBERLAND, MD

| | | • | For State Registrar | State of | Marylan | | artment of H | | | giene | 005 | 380 | 8.0 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------|-----------------------|--------------------------------------------|-------------------------------------|----------------------------------------|-------------|--------------------------------------------------|------------------------------|----------|
| | | | Decedent's Name (First, Middle, L. | ast) | | | | | 2. Date of Dea | ath | | 3. Time of 0 | Death |
| | Physicia /Medic | | Vernon | | Nesbit | | Apple | | Month NOVEMBE | Day CR 3 | Year 2005 | 0928 | М |
| | Examin | | 4a. Facility Name (If not institution, g | ive street and numb | er) | | 4b. City, Town, or | Location of Dea | th | 4c. C | County of Death | | |
| | | | MEMORIAL HOSPITA | | | | CUMBER | | | | LLEGANY | | |
| | Funeral | | | Sex 7. 1 ☑ M 2 ☐ F | Age (In yrs. I | ast birthday) Yrs. | If Under 1 Year Months Days | Hours Min | . (Month, Da) | | Cou | place (State or ntry) | |
| | Director | | Usual Residence of Decedent | | 86 | | | | 08/18/1 | 919 | West | Virginia | |
| | /land | | 10a. State 10b. County | | 10c. City | , Town or Lo | ocation | | | | | 10d. Inside City | Limits |
| | Man a-f sh | tor | WV Minera | 1 | | | Ridgeley | | | | | 1 XYes | 2 🗌 No |
| | or 286 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citize | en of What Cou | intry? | |
| | within 72 hours after death with the Maryland ene. than "neturel", or Itams 23a or 28e-f show the Madred Examination of the motified at | | 34 Bridge Sti | reet | | | | 26753 | | USA | Α | | |
| | tams | Funeral | 11. Marital Status | 12. Was Deced Armed Force | es? | S. 13. | Was Decedent of Hi If Yes, specify Cuba | spanic Origin? (n, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | - 14 | Race - Amer Black, White | | |
| 36 | s afte | by F | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give | □N∘ 1943 | _ | 1 ☐ Yes 2 🖾 No | Specify: | | 5 | Specify: | Thita | |
| Ö | hour tural | ed b | 15. Decedent's | Year or Date | 98: 194. | | dent's Usual Occupa | ition | | 16b. Kind | d of Business/Ir | White ndustry | |
| 5 | n "na | Completed | (Specify only highest of | rade completed) | In 5 . \ | (Give | kind of work done of DO NOT use retired | uring most of we | orking | 700.71 | | , | |
| 212 | with jiene. r tha | mo | Elementary/Secondary (0-12) | Coilege (1-4 | ior 5+) | В | rakeman | | | R | ailroad | | |
| Maryland 21215-0036 | e file al Hyg othe vent, | ВеС | 17. Father's Name (First, Middle, La | st) | | | | 18. Mother's Na | ame (First, Middle, | Maiden S | Sumame) | | |
| <u>a</u> | Menta Menta arked | 2 | Julius | Columbu | S | A | pple | Mary | Alci | inda | Not | ris | |
| a | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than "natural; or Itams 23a or 28e-f show any injury or other traumatic event, it is Marical Examination and be notified at any injury or other traumatic event, it is Marical Examination and be notified at any injury or other traumatic event, it is Marical Examination. | | 19a. Informant's Name/Relationship | | | | ng Address (Street a | | | | | p Code) | |
| €, ≥ | and lealth m 27 her tr | | Thomas G. Apple / s | on | 20h B | | idge Street | , Ridgele | y, West Vii | | | Cours Ctate | |
| Baltimore, | ges 1 t of H if Ita or ot | | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 | ☐Removal from St | ate a | emetery, crei | matory or other place | | le le | | ation - City or T | | |
| ij | t. Pa rtmen rtant: njury | | ' 4 □ Donation 5 □ Other (Special Signature & Fundal Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liquid Service Liqu | | Cum | | Crematory | | 04/2005 | | erland, M | 2 | |
| Ba | permi Depar Impor any ir | | 21. Signature From rai service Co | erisee / | | | 2. Name and Addres | | ums ramily , Cumberlan | | | | |
| | | | 23a, Part1. Enter the disease, or co | mplications that cal | ised the death | n. Do not en | | | | | Lyland 2 | Approximate | |
| L | | | shock, or heart failure. List on Immediate Cause (Final | ly one cause on ear | ch line. | | | | | | | Interval Betw Onset and D | |
| 1 | Physician /Medical | | disease or condition resulting in death) | | ATION I | | NIA | | | | | 5 DAYS | <u> </u> |
| į. | Examiner | | | | 43 4 00113041 | aorioo orij. | | | | | | | |
| | 100 | Je. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o | r as a consequ | uence of): | | | | | | | |
| | cuted nd ransit | Examiner | fugr luirigrad avalur? | C | | | | | | | | | |
| Ó, | e exe ian ai urial-t | EX | resulting in death) Last | Due to (o | r as a consequ | uence of): | | | | | | | |
| 8760, | icate be executed physician and s the burial-transit | dical | • | d | | | | | | | | | |
| 9 | death certific e attending p ad for use as | /Mec | IF FEMALE: | 23c. If yes, outco | ome of pregna | incv | | | | - | | | |
| Вох | attend for us | ian | 23b. Was decedent pregnant in the past 12 months? | 1 Live bin | h 2 ☐ Fetal | death 3 | Ectopic pregnancy Other (specify) | | | 23 | 3d. Date of delive Month | • | ear |
| o. | 0 0 0 | Physician/Me | 1 □ Yes 2 □ No 9 □ Unknown | 9 Unknov | | 5411 56 | | | | | | | |
| <u>a</u> | res that the igned by th be detache | y Ph | Part II. Other significant conditions | contributing to dea | th but not res | ulting in the u | nderlying cause give | en in Part I. | 23e. Did to | obacco us | e contribute to | the cause of de | ath? |
| rds | quires n sign | d by | ISCHEMIC CARDIO | YOPATHY | | | | | 101 | ∕es 2□ | lNo 3 X Pro | bably 4 □U | nknown |
| Records, | The law requires ite has been sign bage 2 should be | Completed | | | | | | | 24a. Was | an | 24b. Were aut | opsy findings a | vailable |
| Re | The lay | mo | | | | | | | | rmed? | prior to co death? 1 ☐ Yes | ompletion of ca | use of |
| Vital | | BeC | 25. Was case referred to medical | | | | 9 | 26. Place of De | eath (Check only o | | | | |
| / | Physicien: this certific ral director, | To E | examiner? 1 □ Yes 2 🏋 No | Hospital: 1 ⊠In | patient 2 | ER/Outpatie | nt 3 DOA Othe | er: 4 🗆 Nursing | Home 5 Resid | dence 6 | Other (Speci | fy) | |
| 0 0 | ng Pt fter th | :uo | 27. Manner of Death 1 ⊠Natural 5 ☐ Pending | 28a. Date of (Month) | Injury Day Year) | 28b. Time of Injury | of 28c. Injury Work | at ? | 28d. Describe h | now injury | occurred | | |
| sio | Attanding r death. actor: After by the fune | catl | 2 Accident investigat 3 Suicide 6 Could no | he | | | | Yes 2 □ No | 1 | | | | |
| Division of | l or Attano after death Diractor: | Certification: | 4 Homicide determine | 289. Flace C | if Injury - At ho g, etc. <i>(Specif</i>) | ome, farm, st v) | reet, factory, office | | 28f. Location (S City or Tox | | Number or Hui | al Houte Numb | er, |
| | To the Hospitel or Attanowithin 24 hours after death To the Funaral Director: completely filled in by the | | 29a. Certifier 1 ☐ Certifying | Physician: To the h | est of my kee | wledne des | h occurred at the tim | e date and place | a and due to the | causa(s) a | and manner as | stated | |
| | 24 hc 24 hc Fun etely | Medical | | | is of examina | | vestigation, in my or | | | | | | |
| | To the Hospitel within 24 hours a To the Funeral Completely filled | Me | 29b. Signature and title of certifier | | | | 29c. License | number | | 29d. Date | signed (Month | Day, Year) | |
|) , | | | > (1) Illia | - to | mN | m | D2540 | 06 | | Nov | EMBER | 14,20 | ∞ |
| ် | 2/IVA/ | | 30. Name and address of person wh | | | | | | | | | 1 | |
| | MN | | WILLIAM LAMM, M.I | 463 | | | E CUMBERLA | AND, MD | 21502 | | | | |
| | Sta | | 31. Date filed (Month, Day, Year) NOV 0 7 2005 | 32. Re | gistrar's Signa | ture | OF a | | | | | | |
| | Regist | ar | 140 A A 4 7002 | Just Bleet . | - 200 | Spark | | | | | | | |

| | | | For State Registrar | State of Maryland | | tment of ificate of | | Mental Hy | ygien Reg. No | | 8081 |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------|-----------------------|--------------------------------|----------------------|--------------------------------------------------------------------------------|-------------------------------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | scar Adkins | | | | 2. Date of D Month Novem | Da | | Time of Death |
| | /Medic | | 4a. Facility Name (If not institution, give s | | | 4b. City, Town, | or Location of De | | 1 | c. County of Death | د ای |
| | | J | + HE MEMOR 5. Social Security Number 6. Sex | | TTAL | If Under 1 Yea | A570N | s. 8. Date of B | idh | TALBOT | (State or Foreign |
| L | Funeral Director | | | M 2□ F 68 | | Months Days | | | ay, Year | Country) | Carolin |
| | Maryland Ind at | tor | 10a. State 10b. County Maryland Carolin | | Town or Loca | | | | | | nside City Limits ☐ Yes 2 ☐ No |
| | ith the or 28s | Director | 10e. Street and Number | | 100010 | 10f. Zip Code | | | | itizen of What Country? | |
| | sath w | | 4950 Hrynko Road | Lot 11 | S 13 W | 2163 | 2 Hispanic Origin? | (Specify Yes or N | | ted States of 14. Race - American Ir | |
| 2 | irs after de II', or Item Xaminer I | by Funeral | 11. Marital Status 1 1 Never Married 2 Amarried 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: | lf \ | Yes, specify Cu | ban, Mexican, Pu | erto Rican, etc.) | | Black, White, etc. Specify: Caucas | |
| 2 | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If the 12 is marked other than "natural," or Items 23a or 28a-f show other traumatic event. It is Moulcal Examinar mast be notified at | Completed | 15. Decedent's Educ (Specify only highest grade | cation completed) College (1-4or 5+) | (Give ki | nt's Usual Occi nd of work don O NOT use retir | e during most of w | rorking | 16b. i | Kind of Business/Industr | |
| 7 | led wit lygiene her tha | | 5 17. Father's Name (First, Middle, Last) | | La | borer | 18 Mother's N | ame (First, Middi | le Maide | Poultry | |
| <u> </u> | should be filed with nd Mental Hygiene marked other tha umatic event, the | To Be | Dallas Aus | stin Adkins | | | | nnie Mae | | | |
| 2 | 12 sho h and 7 Is mu Iraum | | 19a. Informant's Name/Relationship (Typ | | 1 | | | | | or Town, State, Zip Cod , Maryland | |
| ָה ת | thealt | | Dallas E. Adkir 20a. Method of Disposition | 20b. Pi | lace of Disposi emetery, crema | tion (Name of | (200) | Date | _ | ocation - City or Town, | |
| | Page ient o nt: If ry or | | 1 ∰Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | Der | nton C | emeter | ry 11, | /22/05 | Dei | nton, Mary | yland ———— |
| D | permit. Departm Importa any inju | | 21. Signature of Funeral Service License | Moore - | M | | uneral | | | | 21629 Marylan |
| | Pnysician /Medical Examiner | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | Due to (as a consequ | n. Do not enter | the mode of d | ying, such as card | ac or respiratory | arrest, | Apr Inte | roximate rval Between set and Death |
| | D = | iner | if any, leading to immediate cause. Enter Underlying | Due to (or as a consequ | uence of): | | J | | | | |
| ć | oe executed cian and ourial-transit | I Examin | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequ | uence of): | _=- | | | | | |
| 00/00 | ficate t physics the t | edica | | 1. | | | | | | 1 | |
| C. DOX | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregnated 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of deg 9 ☐ Unknown | death 3 🗆 🛭 | Ectopic pregnan Other (s <i>pecify)</i> | | | | 23d. Date of delivery Month Day | Year |
| ŗ | s that t ned by e detai | by Ph | Part II. Other significant conditions cor | ntributing to death but not resu | ulting in the und | derlying cause of | given in Part I. | 23e. Did | tobacco | use contribute to the ca | use of death? |
| ő | equire sen sig rould b | | Liver auch | osis | | | | . 4 | Dyes 2 | 2 □ No 3 □ Probably | 4 Unknown |
| necoras, | The lar ate has page 2 | Completed | | | | | | | opsy formed? | 24b. Were autopsy find prior to comple death? 1 Yes 2 | tion of cause of |
| | Physician: this certific ral director, | Be | 25. Was case referred to medical examiner? | lospital: | FD/0 | | hh ar | eath (Check only | | 0 F011 - 10 - 11 | |
| <u> </u> | 0 0 | on: To | 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. In W | 4 LI NUISIN | 28d. Describe | | 6 Other (Specify) ury occurred | |
| on or vital | ding Phys th. : After this funeral dir | 豆 | Z L Accident | | ome, farm, stre | et, factory, offic | θ | | (Street a | and Number or Rural Roite) | |
| 5 | al or Attending s after death. I Director: After d in by the fune | ertification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At ho building, etc. (Specify | <i>(</i>) | | | | | , | ute Number, |
| 5 | ne Hospital or Attanding F n 24 hours after death. ne Funeral Director: After lletely filled in by the funer. | O | 4 Homicide determined 29a. Certifier 1 Certifying Physics | 28e. Place of Injury - At he building, etc. (Specify sician: To the best of my knowner: On the basis of examinat and manner stated. | wledge, death | | | | | s) and manner as stated | • |
| 5 | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Medical Certificati | 4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier | building, etc. (Specify sician: To the best of my kno- ner: On the basis of examinal and manner stated. | wledge, death | 29c. Lice | opinion, death or | curred at the time | e, date ar 29d. D | s) and manner as stated id place, and due to the ate signed (Month, Day, | cause(s) |
| 5 | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | O | 4 Homicide determined 29a. Certifier 1 Certifying Physical (Check only one) | building, etc. (Specify sician: To the best of my kno ner: On the basis of examinal and manner stated. | wledge, death tion and/or inve | 29c. Lice | opinion, death of | curred at the time | e, date ar 29d. D | s) and manner as stated nd place, and due to the | cause(s) |

| | | | For State Registrar | State of | Marylan | id / Depa <i>Cei</i> | artment of I tificate of | Health and <i>Death</i> | | giene2 (| 005 | 38082 |
|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|------------------------|----------------------------------|----------------------------------|---------------------------------------|-----------------------------------------|-------------------------------|-----------------|--------------|-------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. Date of De | ath Day | Year | 3. Time of Death |
| | Physicia | | Alphonso Lemuel A | rnold | | | | | Novembe | - | 2005 | 0750 M |
| 3 | /Medic Examin | | 4a. Facility Name (If not institution, give s | | ber) | | 4b. City, Town, | or Location of Dea | | | nty of Deat | |
| | E-XBIIIII | - | Peninsula Parison | 1 red | cal C | enter | Salis | Shiril | | 11/ | in | nico. |
| | Funeral | | 5. Social Security Number 6. Sex | | Age (In yrs. | last birthday) | If Under 1 Year | | 8. Date of Bir | th Vone | 9. Birtl | hplace (State or Foreign untry) |
| П | Director | | 055-26-0153 | M 2□F | 73 | Yrs. | Months Days | Hours Min | June 6, | 1932 | | York |
| | | | Usual Residence of Decedent | | | | | | | | | |
| | yłan Mor | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | 10d. Inside City Limits |
| | Mar. | ğ | Maryland Wicomico | | Sa | alisbury | | | | | | 1 ☐ Yes 2 🔀 No |
| | n the | ire | 10e. Street and Number | - | | | 10f. Zip Code | | | 10g. Citizen o | of What Co | untry? |
| | h wit | Funeral Director | 406 Trinity Drive | | | | 2180 | 1 | | US | A | |
| | da al | ner | | 12. Was Deced | | .S. 13. | Was Decedent of | Hispanic Origin? (pan, Mexican, Pue | Specify Yes or No | | lace - Ame | rican Indian, |
| 9 | hours after death with the Maryland turel', or Items 23a or 28a-f show al Examinan must be notified at | 品 | 1 Never Married 2 Married | 1 ☐ Yes | No No | | 1 □ Yes 2 /□X No | | 110 7 110 211, 010.7 | Spe | oifer | |
| 8 | ral', c | i by | 3 ☐ Widowed 4 ☐ Divorced | Year or Da | les: | | 103 21-100 | эрвону. | | 300 | Bla | ack |
| 21215-0036 | 72 h | Completed | 15. Decedent's Edu (Specify only highest grade | cation e completed) | | (Give | dent's Usual Occu | during most of we | orking | 16b. Kind of | | · · |
| 7 | within 72 ene. then "naf | npi du | Elementary/Secondary (0-12) | College (1- | 4or 5+) | life. | DO NOT use retir | ed) | | Heatin | ıg/Plu | mbing Co. |
| 2 | filed wi Hygien other th | Sol | 12th | | | labore | r | | | | | |
| 2 | al Hy al Hy al oth | Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Na | ime (First, Middle | , Maiden Sum | ame) | |
| <u>a</u> | should be and Mental a marked o umatic eve | ဥ | William | | А | rnold | | Marie | | | | Williams |
| Maryland | | 0.0 | 19a. Informant's Name/Relationship (Ty | rpe, Print) | | 19b. Mailir | ng Address (Stree | t and Number or F | Rural Route Numb | er, City or Tov | vn, State, Z | Zip Code) |
| | end 2 Belth n 27 I | | Alphonso Ennis/son | | | | | Orive - M | | | | |
| že | | | 20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ P | lomoval from S | | Place of Dispo cemetery, crer | sition (Name of matory or other pl | ace) | Date | 20c. Locatio | n - City or | Town, State |
| altimore, | permit. Peges Department of i Important: If its any injury or o | | 4 Donatten 5 Other (Specify) | | | shury (| Gremator | v 11/0 | 17/2005 | Salighu | rv M | arvland |
| ======================================= | partn partn ports y inju | 4 | 21. Signature of un ra Service Licens | 96 | 11 | 22 | 2. Name and Add | ess of Facility 1 | 213 Jerse | y Road | - Sa | aryland lisbury, MD |
| m | Depa impo eny i | 1 | falrens! | 1 1 | eleg | | | EMORIAL | | | | 21801 |
| | | | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or | ications that ca | used the leaf | h. Do not ent | er the mode of dy | ing, such as cardia | ac or respiratory a | rrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final | V | CVD | | | | | | | Onset and Death |
| 1 | /Medical | | disease or condition resulting in death) | d | or as a consec | uence of): | | | | | | |
| | Examiner | | | C | - A | , | | | | | | |
| | | e | Sequentially list conditions, if any, leading to immediate | D | or as a consec | (uence of): | | | | | | |
| | uted | m | cause. Enter Underlying Cause (Disease or injury that initiated events | • | | | | | | | | |
| <u> </u> | s be executed siclen and t burial-transit | Examiner | resulting in death) Last | Due to (| or as a consec | (uence of): | | | | | | |
| 8760, | cate be executed physiclen and tha burial-transit | dicai | | d | | | | | | | | |
| .89 | ificate g physi as the b | | | | | | | | | | | |
| ŏ | thet the death certif ed by the attending detached for use a: | by Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outo | | | ne | | | 23d. | Date of del | ivery |
| Ď | death a atte d for | Cia | in the past 12 months? 1 □ Yes 2 □ No | 4☐Pregna | rth 2 ☐ Feta ant at time of c | | Ectopic pregnan Other (specify) | | | | Month | Day Year |
| O. | the sy the ache | hys | 9 □ Unknown | 9□ Unkno | wn | | | | | | | |
| Vital Records, P.O. Box | igned to be det | y P | Part II. Other significant conditions con | ntributing to de | ath but not res | sulting in the u | nderlying cause g | iven in Part I. | 23e. Did | tobacco use c | ontribute to | the cause of death? |
| g | o sign | | | | | | | | 10 | Yes 2□No | 3 □ Pr | obably 4 Donknown |
| 2 | w requir been si should | ete | | | | | | | 24a. Was | an 24 | b. Were au | itopsy findings available |
| Be | he lav | Completed | | | | | | | | ormed? | death? | topsy findings available completion of cause of |
| a | ding Physician: The I h. After this certificete ha funeral director, page | | 05 196 | | | | | Di (D | 1 Yes | 2010 | 1 🗆 Yes | 2[]_N6 |
| ⋚ | certi | Be | 25. Was case referred to medical examiner? | Hospital: | ole ole | £00 | O | thac | eath (Check only | | Dah /0 | -4.1 |
| ō | Phys this ral di | <u>۲.</u> | 1 ☐ Yes 2 ☐ No Control of Death | 28a. Date o | | ER/Outpatier 28b. Time o | IT 3LI DUA | 4 Nursing | Home 5 ☐ Res 28d. Describe | | | city) |
| C | After fune | 들 | 1 Natural 5 ☐ Pending | (Montl | n, Day Year) | Injury | W | ork? ∃Yes 2⊟No | | | | |
| Division of | deatl deatl stor; | Sa | 3 ☐ Suicide 6 ☐ Could not be | 28e Place | of Injury - At h | ome farm sti | reet, factory, office | | 28f. Location | Street and Nu | mber or Ri | ural Route Number. |
| .≥ | or A efter Direction by | Certification: | 4 Homicide determined | | g, etc. (Speci | | e or, radiory, ornor | • | City or To | wn, State) | | |
| | To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours effect death. To the Funeral Director: Affer this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | | 29a. Certifier 1 Cartifying Phy | sician: To the | best of my kn | owledne dest | h occurred at the | time, date and place | ce, and due to the | cause(s) and | manner 26 | stated. |
| | 24 hi 24 hi Fun | edicai | (Check only 2 Medical Exami | | sis of examin. | | | | | | | |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | 2 | | | 29c. Lice | nse number | T | 29d. Date sig | ned (Mont | h, Dey, Year) |
| | F 3 F 8 | | 1 Blace M. |) | | | カニ | 7952 | | | | 005 |
| , | | | DOCK OUT 11. | omoleted | of door the | m (3a) /T | | . , | | | | |
| | | | 30. Name and address of person who co | Unipieted cause | 6 M | torz | (T # 5 | 50413 | Salisbu | my M | 1)21 | 804 |
| | Sta | ato. | 31. Date filed (Month, Day, Year) | 32. Re | Gistrar's Sign | ature | | | - | | - / | / |
| | Regist | | NÓV Ó 9 2 | 005 | EMICHE. | 15 1 | park | | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 10,2005 3:30P M ANNA MARY ATKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LA PLATA CHARLES CHARLES COUNTY NURSING & REHAB. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ F Yrs JAN.10,1912PENNSYLVANIA Director 168-14-1948 93 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits rottiled at 10a. State 1XXes 2 No CHARLES Directo MARYLAND LA PLATA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be tiled within 72 hours atter death with Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or. any injury or other traumatic event, I 20646 10200 LA PLATA ROAD U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XXNo Specity: Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON AVON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS C. KILGORE BERTHA M. MATTHEWS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7438 ROBIN ROAD, LA PLATA, BERTHA O'NEAL-EXECUTOR MARYLAND 20646 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Maurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PINE GROVE CEMETERY 11-18-05 AIRVILLE, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 KAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 e mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that oused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certiticate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 2 No 1 Tyes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide within 24 hours a
To the Funerel I
completely filled Conflying Physician: To the best of my knewledge ideath control at the time, data and place and due to the data (s) and matcher as stated [2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 210 Cutter Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ine Center St 302 Walton 12670 M.Eliael 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State NOV 2.8 2005 Registrar

| | | | For State Registrar | State of N | Marylan | | artment o | | | | Reg. No. | 005 | 380 | - |
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| \$/* | Funeral Director | | 5. Social Security Number 219-03-8729 Usual Residence of Decedent | 6. Sex 7. / 1 ☐ M 2 💢 F | Age (In yrs. | last birthday) Yrs. | If Under 1 Ye Months Da | | Min. | 8. Date of Bir (Month, Da 10-Aug- | y, Year) | 9. Birth Cou Mary | place (State or htry) | Foreign |
| | the Maryland r 28a-f show | Director | 10a. State 10b. County Maryland Allo | egany | | ty, Town or Lo | 10f. Zip Coo | le | | | 10g. Citize | n of What Cou | 10d. Inside City 1 Yes 2 | |
| JU36 | be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28s-f show event, the Madical Examirae must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Mar 3 X Widowed 4 Divorced | If Yes Give | s? ₹ÎNo | | 21532 Was Decedent If Yes, specify 0 | of Hispanic Or Cuban, Mexica No Specify | | city Yes or No Rican, etc.) | Sį | . Race - Amen Black, White, pecify: White | etc. | |
| 21215-0036 | ed within 72 h rgiene. er than "natu f. the Madical. | Completed | (Specify only highe Elementary/Secondary (0-12) | t's Education st grade completed) College (1-40 | r 5+) | 16a. Dece (Give life. | dent's Usual Oc kind of work do DO NOT use re | ne during mos tired) | | | tire ma | of Business/In | | |
| Maryiand | a a b y | To Be | 17. Father's Name (First, Middle, Lewis G. Heiland 19a. Informant's Name/Relations | | | 19b. Maili | ng Address (Str | Sara | h M. F | (First, Middle) Tumphrey I Route Number | 7 | | Code) | |
| Baltimore, Ma | 1 and Health tem 27 | | Lisa Blocher 20a. Method of Disposition 1* Burial 2 Cremation 4 Donation 5 Other (5 | | 20b. f | Place of Disponentery, cre- | virett Aven position (Name of matory or other memorial Pa | place) | D | oerland ov-2005 | 20c. Loca | yland tion - City or T | 21502 own, State | |
| Pair | permit. Pages Depertment of Important: if it any injury or one. | | 21. Signature of Euneral Service | Licensee A WY | of | 2: | 2. Name and Ad Durst Fu | dress of Facil | • | Frost A | ve., Fro | stburg, N | /ID 215 | |
| 8760, | Physician /Medical Examiner physician and physician and physician ithe physician and physician are physician and physician are physician and physician are physician and physician are physician are physician and physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are p | licai Examiner | 23a. Part Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to an involute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or : | as a consec | dend quence of): | Jaihux | | | | | | Approximate Interval Betwo Onset and Do | een |
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| | v requires the been signed should be de | Completed by Ph | Part II. Other significant conditions of the Court Shape of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court of the Court | ons contributing to death stro antenti Turker | | | , , | 3 | | 1 🗆 | Yes 2 | No 3 Prol | he cause of de bably 4 Arr | nknown |
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| Division of Vital Records, | To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page | Certification: To | 1 Yes 2 6 27. Manner of Death To Natural 5 Pendii 2 Accident invest 3 Suicide 6 Could detern | 28a. Date of li (Month, li gation not be | njury Day Year) Injury - At h | 28b. Time of Injury | of 28c. | njury at Work? 1 □ Yes 2 □ |]No | 28d. Describe | how injury of Street and I | | fy) al Route Numb | 1007, |
| อ์ | To the Hospital or Attano within 24 hours after death To the Funaral Director: completely filled in by the | Medicai Certi | 29a. Certifier Certifyin | ng Physicien: To the be Examiner: On the basis | of examina | owledge, dear | th occurred at th | e time, date a | nd place, a | City or To | cause(s) ar | nd manner as s | stated. o the cause(s) | |
|) | To the within 2 To the comple | Mec | 29b. Signature and title of certifies Sum | r | | | | cense number | 4 | | | signed (Month, | | |
| 177 | かん) St Regist | ate rar | 30 Name and address of person Ar. Jesus Tan 31. Date filed (Month, Day, Year NOV 1 4 | 10701 N | ew (strar's Sign | m 23a) (Type | S Cre | ek R | d. Fr | ostbur | g,M | arylar | d 215 | 132 |

State of Maryland / Department of Health and Mental Hygiene U U For Stata Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Grace Finzel Bittner November 05, 2005 11:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Allegany 16 Standish Street Frostburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs. 212-38-5684 96 Director 28-Dec-1908 Marvland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tiem 27 Is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, its M. Alical Examinar research 200.00. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number16 Standish Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ira Finzel Barbara Anna Finzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253 Shaw St. Enordo Arnone friend Frostburg Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 08-Nov-2005 Finzel Finzel Cemetery Maryland 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DICATION onfumeni disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 12 Name and address of person

Registrar

State

31. Date filed (Month, Day, Year)

NOV 0 7 2005

mpleted cause of death (Item 23a) (Type, Print) MD

32. Registrar's Signature

| | | | | State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 005 38086 |
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| • | | Examin | er | memorial Hospital Easton Talbot |
| | E. | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1999. Birthplace (State or Foreign |
| | 1 | Director | | 218-20-5034 79 Yrs. Sept 16 1926 Delaware |
| | - | pue * | | Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits |
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| | | deat | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. |
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| 10 | lan | 2 sho and I Is me | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| 70 | 5, | and iealth m 27 | | Amy Bell/spouse PO Box 701 Greensboro, Maryland 21639 20a Method of Disposition Date 20c. Location - City of Town, State |
| F | Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examination and the mailined at once. | | 1 St Burial 2 Cremation 3 Removal from State |
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| Bell, Floya | Bal | Departing Departing Important in Englishment | | Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, MD 21639 |
| , | п | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death |
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| | Box | The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as th | Physician/Med | 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year |
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| | Division of Vital Records, P.O. | or At after d Direct in by | Certification: | 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |
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| | | To the Hospitel or Attending Phyelcian: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director; § | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
| _ | | To th Within To th comp | M | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) |
| | | | | Jennis M & Ahald 20053110 Nevember 14, 2005 |
| | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |
| | | | | Dr. Dennis DeShields 219 S. Washington Street Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature |
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| | | □ 38 · × λ | 4.00 | MAN TO COOK TO THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK TH |

State of Maryland / Department of Health and Mental Hygien 🛭 🕦 🖯 38087 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** November 10 2005 6:25 A Pauline Anna Buckle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Caroline Home for Hospice Denton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Feb 20 192 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕅 F 1924 215-20-4817 81 Delaware Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2X No Maryland Caroline 27511 Sandtown Road Goldsboro Direct the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21636 USA Items 23a 27511 Sandtown Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. 08 seamstress manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary (unknown) Arrington Walter Arrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred W. Buckle, Jr./ husband 27511 Sandtown Road Goldsboro, Maryland 21636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/05 Greensboro, Maryland 4 □Donation 5 □ Other (Specify) Greensboro Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639 Key 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Tegen Approximate Interval Between Onset and Death Immediate Cause (Final metastatic weeks Physician disease or condition resulting in death) C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Division of Vital Records, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) hospice house Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: After 1 Matural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation ours after death.

neral Director: A
filled in by the for 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0047534 0

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State Registrar

P.O. Box 68760

920 Market Street Denton, MD 21629

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Wafik Zaki, MD

1 4 2005

31. Date filed (Month, Day, Year)

| | , | State of Maryland / Department State of Maryland / Department State of Maryland / Department Certificate | t of Health and N e of Death | Mental Hygie Reg. | /11115 | 38088 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------|--------------------------------|----------------------------------------------------|
| | | Decedent's Name (First, Middle, Last) | | 2. Date of Death | NO. | 3. Time of Death |
| Physic | | Florence Buila | | Hovenber | Day Year | 2342 M |
| /Medi Examir | | | Town, or Location of Death | | 4c. County of Deat | |
| LAdiiii | ICI | | stown | | Washingto | n |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under | 1 Year If Under 24 Hrs. | | | hplace (State or Foreign untry) |
| Director | | 379-24-2965 1□ M 2⊠ F 92 Yrs. Months | Days Hours Min. | October 3 | 1913Mich | igan |
| p , | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits |
| anyla shov | ٦ | | | | | 1 ☑ Yes 2 ☐ No |
| he M | Director | Maryland Washington Williamsport 10e. Street and Number 10f. Zig | Codo | 100 | Citizen of What Co | |
| a or | 늅 | | | | | unity: |
| eath | Funeral | 234 Otho Holland Dr. 2179 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. | dent of Hispanic Origin? (Sp | | S.A. | rican Indian. |
| fter d | Fun | Armed Forces? If Yes, special No. 1 ☐ Yes 2 ☒ No. | cify Cuban, Mexican, Puerto | o Rican, etc.) | Black, White | |
| hours af | by | 3 Widowed 4 Divorced If Yes, Give 1 Yes | 2⊠ No Specify: | | Specify: Wh | ite |
| 72 ho | Completed | 15. Decedent's Education 16a. Decedent's Usus (Specify only highest grade completed) (Give kind of wo | al Occupation rk done during most of work | ting 16t | . Kind of Business/ | |
| P | ple | Elementary/Secondary (0-12) College (1-4or 5+) | se retired) | King | | |
| A will will will will will will will wil | Con | 12 3 L.P. Nurse | | | edical | |
| yland build be file Mental Hy arked oth etic event | Be | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, Mai | den Sumame) | |
| ife, Maryland ZIZIS-DUSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other then "neturel", or items 23s or 28e-f show other treumetic event, the Medical Eventing must be ruitified at | 2 | Peter Buila | | stelnick | | |
| War d 2 sh th and th and t7 1s m treum | | | (Street and Number or Ru | | • | |
| e, n 1 and 1 and Health 9m 27 ther ti | | | an Head, Bry | | Maryland Location - City or | |
| ges 1 t of t if ite or ot | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State | ther place) | | | |
| timen timen tent: | | '4 □Donation 5 □Other (Specify) Rest Haven Ce | | | | |
| Daltimore, Misperin, Pages 1 and 2 Department of Health a Importent: If item 27 it any injury or other tre once. | | | d Address of Facility Re | | | - |
| 4 | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the modern that caused the death. | ennsylvania . | | | 1. ZI/4Z Approximate |
| | | shock, or heart failure. List only one cause on each tine. | | or roop raior, | · | Interval Between Onset and Death |
| Physician /Medical | | disease or condition a. MYDCAKDIAC INFA | RCTION | | | |
| Examiner | | Due to (or as a consequence of): COROWARY ARTERY | DICEASE | | | |
| ÷ | e | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 201120 | | | |
| uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events ATHEKOSCEENDTIC HE | ART DISCA | 5 E . | | |
| exector an an an rial-tr | | resulting in death) Last Due to (or as a consequence of): | | | | |
| OX b8 / bU, certificate be executed riding physician and use as the burial-transit | dical | d | | | | |
| rtifica ng ph | Med | IF FEMALE: | | | | |
| BOX bath cer attendir | an/I | 23b. Was decedent pregnant in the past 12 months? | regnancy | | 23d. Date of deli | very Day Year |
| COTGS, P.O. BOX by wrequires that the death certific been signed by the attending I should be detached for use as | hysiclan/Me | 1 Yes 2 No 9 Unknown 5 Other (sp | ecity) | | 1000 | Duy Tour |
| hat the deby detacl | 0 | Part II. Other significant conditions contributing to death but not resulting in the underlying of | ause gwen in Part I | 23e. Did tobac | co use contribute to | the cause of death? |
| OrdS, F. requires that | by | Farth. Stror significant solutions contributing to south out his resulting in the underlying to | auso givoir irr arri. | | | obably 4 Unknown |
| requisional | etec | | | 24a. Was an | 045 144 | to a second and a second about |
| VICAL RECOICAS, sicien: The law requires t certificate has been signe irector, page 2 should be (| Completed | | | autopsy performed | prior to o | topsy findings available completion of cause of |
| at a | | DE Was ages referred to medical | 20 8 | 1 ☐ Yes 2 ☑ | | 2 No |
| Of VICAL Physicien: T this certificat ral director, pa | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC | Other | th (Check only one) | - C [] Other (C | |
| Phy Phy ral d | - | 27. Manner of Death 28a. Date of trijury 28b. Time of 2 | 8c. trijury at | 28d. Describe how i | | siry) |
| tending Phys death. tor: After this crite funeral dir | tlor | 1 🗹 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M | Work? 1 ☐ Yes 2 ☐ No | | | |
| UNISION I or Attending after death. Director: Afte | ifica | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor | , office | 28f. Location (Stree | t and Number or Ru | ral Route Number, |
| To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Certification; | 4 ☐ Homicide building, etc. (Specify) | | City or Town, S | rare) | |
| ospit hour unere | | 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation | | | | |
| the H lin 24 the F | edical | one) and manner stated. | | | | |
| To To | Σ | Los organization and this or octavity. | . License number | | Date signed (Month | |
| | | . , | D62562 | | 1-19-05 | |
| 5 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M WASHING TON COUNTY MOSPITAL 251 E | | | 14/ (| 200 3121 · |
| | | 31. Date filed (Month, Day, Year) 32. Begistrar's Signature | ANTI ETAM S | INCEL! F | MACRITUL | שאווג עמו אנ |
| St Regist | ate rar | NOV 2 8 2005 | • | | | |
| | • | MON AS O (UUS) Produces (To Constant) | | | | |

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ORIGINAL

| | | Decedent's Name (Fig. 1) | irst, Middle, | State state 23a, 24 Last) | 4 | | | | | | 2 Date of De | ath | | /ear | 3. Time of | Death |
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| hysici: Medic/ | | Georg | ge Fre | derick | Benchof | f | | | | | Novemk | er 02 | 3 20 | 05 | 0505 | AM |
| Examin | | 4a. Facility Name (If not | | | | | 4b. City, T | Town, or | Location of | of Death | | | County of | | | |
| | | Washingt | ton Co | unty Ho | spital | | 1 | *** | town | | | | | | gton | |
| neral ector | | 5. Social Security Numb | 41 | 5.Sex 1 [X]M 2 □ F | | s. last birthday) 84 Yrs. | | 1 Year Days | If Under Hours | Min. | 8. Date of Bi (Month, Di Jun 30 | $\frac{1}{192}$ | 21 | 9. Birthp Coun | lace (State o. etry) PA | Foreig |
| | } | Usual Residence of Dec 10a. State 10 | b. County | | 10c. (| City, Town or L | ocation | | | | | | | 1 | 0d. Inside Cit | y Limits |
| 7 | ō | PA | Franl | klin | | B1u | e Ride | ge Si | ummit | | | | | | 1 ☐ Yes | 2 🔯 No |
| Examiner must be notified at | Funeral Director | 10e. Street and Number | | | | | 10f. Zip | | | | | 10g. Citi | izen of Wh | at Coun | try? | |
| 2 | ai D | 1 43 7 4 <i>B</i> | A Carr | osmar F | arm Roa | ıd | | 17 | 214 | | | | US | SA | | |
| E P | ner | 11. Marital Status | | 12. Was De Armed I | cedent Ever in | U.S. 13. | Was Decede | dent of His | spanic Ori | gin? (Spe | ecify Yes or No Rican, etc.) |)- | 14. Race - | Americ White, | | |
| | y Fu | 1 Never Married | | d 1 G√Yes | 2 No | | 1□Yes 2 | | | | , , , , , | | Specify: | Whi | | |
| | d by | 3 ☐ Widowed 4 ☐ | | Year or | Dates: 40-4 | | | | | | | 100 100 | | | | |
| | Completed | 15. (Specify o | Decedent's only highest | grade completed | d) | 16a. Dece | edent's Usual e kind of work DO NOT use | il Occupa rk done di se retired) | ition <i>Juring m</i> os | t of work | ing | 16b. Ki | ind of Busi | ness/inc | dustry | |
| | ш | Elementary/Secondar | ry (0-12) | College | (1-4or 5+) | | ntenan | | - | | | | US Go | over | nment | |
| | Ö | 17. Father's Name (Firs | | | | | | | 18. Mothe | er's Name | (First, Middle | , Maiden | Sumame) |) | | |
| 2 | To Be | Carl W. | Bench | off | | | | | Anı | na Ma | ay Happ | e1 | | | | |
| othar treumatic svent, the medical | - | 19a. Informant's Name | /Relationshi | р (Туре, Print) | | 19b. Maili | ing Address | (Street a | nd Numbe | er or Rura | al Route Numb | er, City o | r Town, St | tate, Zip | Code) | |
| | | Carrie V. | Bench | off | Wife | | | | | lue 1 | Ridge S | ummi | t, P/ | A 17 | 2 1 4 | |
| | | 20a. Method of Disposit | | T Domeyal from | 20b | . Place of Dispo cemetery, cre | osition (Name | ne of ther place | 9) | [| Date | 20c. Lo | cation - Ci | ity or To | wn, State | |
| | | 1 ☐ Burial 2 🔯 Ci '4 ☐ Donation 5 ☐ | | | | unberland | | | | Vov. | 9 2005 | Way | nesbo | oro, | PA | |
| ODCS. | | 21. Signature of Funera | al Service Li | censee | | 2 | 2. Name and | d Address | s of Facilit | yGro | ve-Bowe | rsox | Fune | eral | Home, | In |
| a a | | | ute V | | re | 1 9 | 50 S. | Broa | d St. | . War | ynesbor | o. P | A 172 | 268 | | |
| ician dical niner | _ | 23a. Part1. Effer the d shock, of heart fa Immediate Cause (Fina disease or condition resulting in death) Sequentially list conditions to the condition of the condition in the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of | | a. Due t | o (or as a cons | obably equence of): | | e of dying | o rec | | | | | | Approximate Interval Between and E | yeen leath |
| iner iner | cal Examiner | disease or condition | ions, diate ng ry | abbb | of the | equence of): | relate | e of dying | o rec | | | | | | Approximate Interval Between Ages and C | veen leath |
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Amended Items 10c & 20a per F.D. 11/10/2005 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2005 38090 |
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| Physic | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year M |
| /Med Exami | | Charles Kenneth Crum 4a. Facility Name (If not institution, give street and number) Carroll Lutheran Health Care Center 4b. City, Town, or Location of Death 4c. County of Death Carroll |
| Funeral Director | | 5. Social Security Number 218-14-6255 6. Sex 1 Representation of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the sec |
| yland | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits |
| he Mar 88e-1 s | Director | Maryland Carroll Wethminster Westminster |
| re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural; or itame 23s or 28e-f show other treumatic event, the Medical Examiner must be notified at | by Funeral Dir | 106. Street and Number 200 St. Luke Circle 11. Marital Status 1 |
| 21215-0036 solvithin 72 hours aft giene er then "natural", or the Medical Exami | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry |
| laryland 212' 2 should be filed within and Mental Hygiene. ie marked other than eumatic event, the M | BeC | 12 Accountant Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |
| Maryland d 2 should be file th and Menta! Hy ?? Ie marked oth treumatic event | To | William S. Crum Mamie M. Groshon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| e, Ma 1 and 2 si Health an em 27 le r | | Teresa Wagner/Daughter 375 Kingsbury Way #23, Westminster, MD 21157 |
| O O | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State |
| Baltimore, permit. Pages 1 a Department of Her Importent: If Item any Injury or othe once. | 8 1 | 1 □ Donation 5 □ Other (Specify) Kriders Cemetery 11-14-2005 Westminster 21. Signature of Funeral Service Licensee 22 Printed Address of Funeral Home & Chapel, P.A. |
| TO 202 % 9 | | 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate |
| Wedical Cate be executed Examiner Sphysicien and Ithe burial-transit | dical Examiner | disease or condition resulting in death) Sequentially list conditions, reany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): |
| I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant at time of death 6 Other (specify) Month Day Year 6 Other (spe |
| Cords, For requires that been signed should be def | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| | Completed | 24a. Was an autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \ 2 \(\text{N} \) No \[1 \] Yes \[2 \(\text{N} \) No |
| of Vita Phyeicien: this certificated director. | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No |
| ision o' | | 27. Manner of Death Sala Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe |
| Virginia de la constanta de la | Certification | 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural Route Number, City or Town, State) |
| To the Hospitel within 24 hours a To the Funerel I completely filled | edical (| 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
| WS | W | 29b. Signature and title of certifier D 51705 29d. Date signed (Month, Day, Year) 11-10-05 |
| 20 | ato | 30. Name and address of person who completed cause of death (Item \$3a) (Type, Print) DR, Westminster, MD 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature |
| Regis | ĸ | NOV 1 0 2005 Keen & Spell |
| Second 15 Dev 1/ | | ORIGINAL |

| | | | 1- For State of Maryland / | | artment of | | | | jiene | 5 38091 |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------|------------------------------------|------------------|-------------------------------------------|---------------------------------|---------------------------------------------------------------------------------|
| ľ | Physicia | | 1. Decedent's Name (First, Middle, Last) Lelia Blanche Crispin | | | | | 2. Date of Dea Month | th Day V | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) Carroll Hospital Center | | 4b. City, Town | or Location of | | | 4c. County of | |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 □ M 2 🟋 84 | oirthday) Yrs. | If Under 1 Yea Months Day | ar If Under | | 8. Date of Birth (Month, Day Dec 2, | Year) 9 | Birthplace (State or Foreign Country) Maryland |
| | yland how | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow | wn or Lo | cation | ** | | 1 | | 10d. Inside City Limits |
| | the Mar 28a-f sl | ector | Maryland Carroll 10e. Street and Number | | 10f. Zip Code | Hamps | steac | | 0g. Citizen of Wha | 1 ☐ Yes 2 🕅 No |
| | ath with | Funeral Director | 3820 Sunnyfield Court 1A | | | 210 | | | USA | |
| 036 | be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, it a Madical Exerticer must be recilised at | | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 | Was Decedent or If Yes, specify Cu 1 ☐ Yes 2€ N | | | cify Yes or No- Rican, etc.) | | American Indian, White, etc. White |
| 9500-612 | in 72 ho natur | Completed by | (Specify only highest grade completed) | a. Deced (Give life. | dent's Usual Occ kind of work don DO NOT use reti | supation ne during mos ired) | at of workir | ng | 16b. Kind of Busin | ess/Industry |
| 7 | filed withi Hygiene. other thar | Comp | Elementary/Secondary (0-12) College (1-4or 5+) | | Homemak | er | | | Own H | ome |
| Maryland | should be filed withir Mantal Hygiene. markad other than matic evant, to M | To Be | 17. Father's Name (First, Middle, Last) Carroll C. Graham | | | | | (First, Middle, I Iundtern | Maiden Sumame) 1ark | |
| Mar | 2 8 8 D | i | | | - | | | | r, City or Town, Sta and, MD | |
| ore, | Pages 1 and 2 nent of Health int: If item 27 inty or other tru | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State | of Dispo | sition (Name of matory or other p | nlace) | D | ate | 20c. Location - Cit | y or Town, State |
| Baltimore, | permit. Pag Department Important: t any injury o | | 1. Signature of Fyneral Service Licensee 21. Signature of Fyneral Service Licensee 24. 200723 | _ | Cremation Cremation Name and Add | | |)/2005 Eline Fu | Hampste neral Ho | |
| ă E | P o II i i i | | 23a Part Enter the disease or complications that caused the death. Dr. | | | | n St, | Hampst | ead, MD | 21074 |
| | Physician | | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | | oniq | , | | ,, | , | Interval Between Onset and Death |
| | /Medical Examiner | | Due to (or as a consequence | e of): | | | | | | 3 days |
| | rted | Examiner | if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury | e of): | | | | | | |
| ,09/ | ate be executed hysician and the burial-transit | icai Exa | that initiated events cresulting in death) Last c. Due to (or as a consequence | в of): | | | | | | |
| 9 | ntificate ing phys a as the | Medic | IF FEMALE: | | | | | | | |
| O. Box | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown | | Ectopic pregnar Other (specify) | | | | 23d. Date o Month | f delivery Day Year |
| Records, P. | w requires that the deben signed by the should be detached | by | Part II. Other significant conditions contributing to death but not resulting | in the u | nderlying cause | given in Part I | | | 1 | te to the cause of death? Probably 4 Unknown |
| | | Completed | atual dibulation & LI | _Cu Sunt | d Chowshi | Lype | <u>C</u> Phon | - | ped? dea 200 No 1 □ | e autopsy findings available r to completion of cause of th? Yes 22 No |
| f Vital | nysiciar ns certif I director | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 AInpatient 2 EP/O | Outpatier | nt 3 DOA | Othor | | (Check only on ne 5 ☐ Reside | ne) ence 6 □Other (| Specify) |
| o uo | r Attanding Pher death. Frector: After the by the funeral | | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) | . Time of Injury | W | ijury at Vork? □ Yes 2 □ | | 8d. Describe ho | ow injury occurred | |
| Division of | 5 th 10 in | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, 1 building, etc. (Specify) | farm, str | reet, factory, office | ce | 2 | 28f. Location (Si City or Town | | or Rural Route Number, |
| | To tha Hospital or within 24 hours afte To the Funeral Dir completely filled in | edicai | 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated. | | | | | | | |
| | To the complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex | M | 29b. Signature and title of certifier | | | ense number 230 | 115 | 2 | 9d. Date signed (A | doeth, Day, Year) |
| | MIL | | 30. Name and address of person who completed cause of death (Item 23a) | | Print) | D.S. K | | La, M.D. | 57 | 1'1' |
| | Sta | ate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | WE: | SIMINS | 141 | Mo | 211 | 7 | |
| | Registr | ar | NOV 1 0 2005 Strawn & | X A | Goods | | | | | |

| | FUL | partment of Health and Me ertificate of Death | ental Hygiene |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Physician | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Yeer 3, Time of Death |
| /Medical Examiner | John James Clough, Jr. 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | November 15 2005 8:00A |
| Examiner | 16779 Jones Road | Henderson | Caroline |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd. | y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) |
| Director | 217-54-7203 1 X M 2 L F 55 Yrs | 4 | Aug 08 1950 Delaware |
| show adult | 10a. State 10b. County 10c. City, Town or | Location | 10d. Inside City Lim |
| or 28a-f al | Maryland Caroline Henderso | n | 1 ☐ Yes 2 X I |
| bene Dire | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| r items 23a or 28a-f sho ifractivast be notified at Funeral Director | 16779 Jones Road 11. Marital Status 12. Was Decedent Ever in U.S. 1 | 21640 3. Was Decedent of Hispanic Origin? (Spec | U • S • A • ify Yes or No- 14. Race - American Indian, |
| こ 世 正 | Armed Forces? 1 □ Never Married 2 🕅 Married 1 □ Yes 2 🛣 No | If Yes, specify Cuban, Mexican, Puerto P | lican, etc.) Black, White, etc. |
| D | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No <i>Specify:</i> | Specify: White |
| t, the Male | (Specify only highest grade completed) (G | cedent's Usual Occupation ive kind of work done during most of workin a. DO NOT use retired) | g 16b. Kind of Business/Industry |
| than men | Elementary/Secondary (0-12) College (1-4or 5+) | abled | N/A |
| d other event, Be C | 17. Father's Name (First, Middle, Last) | | (First, Middle, Maiden Surname) |
| atic e | John James Clough, Sr. | Margaret | Elizabeth Schofield Clough |
| is m | | , | Route Number, City or Town, State, Zip Code) |
| ther t | | | ayton, DE 19938 tte 20c. Location - City or Town, State |
| t: If it | 1 Burial 2 23 Cremation 3 Hemoval from State | ke Cremation 11/19 | 105 |
| Important: If item 27 Is marked other than any injury or other traumatic event, the Monea. | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility | Chester, Maryland Cin Funeral Home, PA Co, MD 21639 |
| 24 | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. | | |
| physician and the burial-transit and the burial-transit and adjoint and the burial-transit | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | e Sleep apre | a |
| d by the attending phetached for use as the Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 Ectopic pregnancy 5 Other (specify) | 23d. Date of delivery Month Day Year |
| igned be deta | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? |
| should be | Dianetes, Charcot foot | P A THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF T | 1 Yes 2 No 3 Probably 4 Unkno |
| r this certificate has been siral director, page 2 should | U | | 24a. Was an autopsy performed? 1 Ves 2 No 1 Yes 2 No |
| s certification director | 25. Was case referred to medical examiner? Hospital: | 26. Place of Death | |
| After this funeral di | 1 Yes No Injury 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury (Month, Day Year) | of 28c. Injury at 2 | e 5 X Residence 6 Other (Specify) Bd. Describe how injury occurred |
| To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral medical Certification; | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | street, factory, office | Bf. Location (Street and Number or Rural Route Number, City or Town, State) |
| o the Funera ompletely fille Medical C | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, d Check only one) Certifying Physician: To the best of my knowledge, d Certifying Physician: To the best of my knowledge, d and manner stated. | | |
| To t | 29b. Signature and title of certifier | 29c, License number | 29d. Date signed (Month, Day, Year) |
| | 30. Name and address of person who completed cause of death (terr) 23a) (ty | HOD576873 | November 17, 2003 |
| | 215 Old Town Rd Goldsbor | 8 MD 21636 | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 1 8 2005 | anoste s | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** November 2005 6:00P Elizabeth Mary Chupek /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 523 Market Street Denton

der 1 Year | If Under 24 Hrs. | 8. Date of Birth
hs | Days | Hours | Min. | (Month, Day, Year) Caroline If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 □ ¥F Director 2. 1928 Pennsylvania 087-22-4932 Usual Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State itam 27 is marked othar than "natural", or itams 23a or 28a-f show othar traumatic avant, the Medical Examinating in the boundified at 1√ Yes 2 No Maryland Caroline Denton Director 10g. Citizen of What Country? America 10f. Zin Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiane
Important: If itam 27 is marked other than "natural", or Itams 23a
any pilury or other traumatic avant, the Medical Executive context. 523 Market Street 21629 United States of Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Gardosik Elizabeth Kocurek မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 523 Market Street, Denton, Maryland 21629 ce of Disposition (Name of Date 20c. Location - City or Town, State Joan M. Nagel Daughter 20b. Place of Disposition (Name of cemetary, crematory or other place)
Maryland Eastern
Shore Veterans' Cemetery 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/2005 Hurlock, Maryland 22. Name and Address of Facility

Moore Funeral Home, P.A. 21. Signature of Funeral Service License 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland Approximate Interval Between Onset and Death receivent Immediate Cause (Final Breast Concer 10 years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Concestive al Elbrillation -1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No per thy void sz 24a. Was an page 2 autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier sele a Siling 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -5 (growd & Easton mb 2160) & Schillian DV 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

| | | | - FOI | partment of Health and Me | ental Hygier | 2005 | 38094 |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------|----------------------------------------------------|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) Mildred Lee Coulbourne | | 2. Date of Death Month IOV. 11, | Day 2005 | 3. Time of Death 0530 M |
| | /Medic Examin | er | 4a. Facility Name (If not institution, give street and number) 3186 Choptank Road | 4b. City, Town, or Location of Death Preston | | Carolin | e |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 215-01-9161 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda | Months Dave Hours Min | 8. Date of Birth (Month, Day, Yes Sept. 29, | 9. Birth Cou 1919 Mary | place (State or Foreign intry) 1 a n d |
| _ | show | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD Caroline | Preston | | | 10d. Inside City Limits 1 ☐ Yes 2√☐ No |
| | th the M or 28a-f | Funeral Director | 10e. Street and Number | 10f. Zip Code | | Citizen of What Cou | |
| | ms 23a | neral [| 3186 Choptank Road 11. Marital Status 12. Was Decedent Ever in U.S. 1 | 21655 3. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri | | 14. Race - Ameri | ican Indian, |
| 036 | al', or ite | þ | Armed Forces? 1 Never Married 2 Married 1 Yes, Give 3X Widowed 4 Divorced Year or Dates: | 1 ☐ Yes 2 ☐ No Specify: | ilcan, etc.) | Black, White | hite |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, it.e. Medical Examinating routilised at once. | Completed | (Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+) | ocedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired) Memaker | g | . Kind of Business/Ir | ndustry |
| ind 21 | be filed w ital Hygier id other th avent, Ita | Be | 12 Holl 17. Father's Name (First, Middle, Last) Nathaniel Lewis Blades | 18. Mother's Name (| (First, Middle, Maid | | |
| Maryland | should and Men s marke umatic | 2 | 19a. Informant's Name/Relationship (Type, Print) 19b. Ma | ailing Address (Street and Number or Rural | | ty or Town, State, Zi | p Code) |
| É, | and 2 lealth a lm 27 is | | | 86 Choptank Rd., | | . Location - City or T | |
| mor | Pages ent of h nt: If ite ry or of | | cemetery, c | crematory or other place) | | | Maryland |
| Baltimore, | permit. P Departm Importar any inju | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility Fra 216 N. Main St., | | | Home, P.A. MD 21632 |
| ľ | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | respiratory arrest, | | Approximate Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) Due to (or a a consequence of): | Carcinoma | | | & months |
| | Examiner | e. | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | |
| | and transit | Examiner | cause. Enter Underlying Cause (Disease of Influir that initiated events resulting in death) Last C | | | | |
| 8760, | ate be executed hysician and the burial-transit | cal | d. | | | | |
| .O. Box 68 | death certific e attending p ed for use as | Physician/Med | | 3 □Ectopic pregnancy 5 □ Other (specify) | | 23d. Date of deliv | very Day Year |
| Δ. | uires that the signed by Id be detac | by | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobaco | co use contribute to | the cause of death? |
| I Records, | The law requires that the ate has been signed by the page 2 should be detache. | Completed | | | 24a. Was an autopsy performed 1 Yes 2 1 | prior to co | opsy findings available ompletion of cause of |
| Vital | sician: certific rector, | o Be (| 25. Was case referred to medical examiner? 1 Yes | 26. Place of Death | | e 6 ☐Other (Speci | (fe) |
| of | | H- | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury | te of y Work? | 8d. Describe how in | | 19) |
| Division | or Attendii fter death. Jiractor: A in by the fu | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | M 1 ☐ Yes 2 ☐ No , street, factory, office | 8f. Location (Street City or Town, St | t and Number or Rur tate) | ral Route Number, |
| נ | To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune | edical Ce | 29a. Certifier (Check only one) 29 Medicel Exeminer: On the basis of examination and/o and manner stated. | | | | |
| | To the within To the comple | Me | 29b. Signature and title of certifier Challe DO | 29c. License number + + + + 7 3 5 7 | 1 | Date signed (Month, | |
| , | | | 30 ame and address of person who com leted cause of death (item 23a) (Ty | pe, Print) | 0. | 11-15-26 e L. Gr | 1 4 5 |
| | Ct. | ate | 31. Date filed (Month, Day, Year) 32 Registrar's Signature | 204 Easton MD | Thn | e L. Gr | ady D.O. |
| | Regist | | NOV 1 5 2005 | hade | | | |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 04, 2005 2:05a [™] Nov. BERNICE M. Cannon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury 4883 Snow Hill Road If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 🗙 F 79 Director 8/31/1926 Virginia 227-42-6881 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 7 Is marked other than "natural", or Items 23e or 28e-f show traumatic event, the Medical Examinat must be notified at TYes 2 □ No Salisbury Wicomico Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4883 Snow Hill Road 21804 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other trainmetin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marguerite Ruff William Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4883 Snow Hill Rd., Salisbury, MD 21804 Geneva Cannon (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gardens 11/11/2005 Hebron, MD ^¹ 4 □ Donation = 5 □ Other (Specify) 22 Name and Address of Facility Holloway Funeral Home Professional Association Signature of Funera Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 19a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluss on each the. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Physiclan/Medical use as the ď IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 1 10 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident filled in by the hours after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4422 21851 Sarad Paral 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 604- Market Tocomoke 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 9 2005 Heren B. Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** NOVEMBER MARY ELIZABETH CLEGG 15, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA, MARYLAND
If Under 1 Year | If Under 24 Hrs. | 8. Dat
Months | Days | Hours | Min. | Min. CHARLES 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖾 F Yrs. Director 577-34-3200 85 JUNE 22,1920 S.C Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **ehow** 27 is marked other than "naturel", or Iteme 23s or 28s-f shot traumatic event, its Madical Examinar must be notified at XXYes 2□No MARYLAND CHARLES LA PLATA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 MAGNOLIA DRIVE 20646 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Marned 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: ₩idowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE PRIVATE DUTY NURSE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If tiem 27 is marked any injury or other traumatic events. JOHN GILLIARD EMMA GILLIARD 19a. Informant's Name/Rejationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRY SARVIS-SON 10429 CRESCENT PARKWAY, WALDORF, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial % Cremation 3 Removal from State 4 Donation 5 Other (Specify) M.F. METROPOLITIAN CREMATORY 11-22-05 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 21. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death PNEUMONI Physician DAY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): 9 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, been signe should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably # ☑ Unknown Completed CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has 1 Yes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) all or Aus.

vars efter death.

veal Director; After this so by the funeral director. Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 of au NOV D-44436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVIN J., MD 102 PAUL MELLON COURT SUITE 102 WALDORF MARYLAND 20602 31. Date filed (Month, Day, Year) State NOV 2 8 2005 melle Registrar

| ٥, | | | For State Registrar | State | of Marylar | - | artment of tificate or | | ind Mental | Hygien Reg. N | 2000 | 29007 |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------|----------------------|----------------------------------------------------|-----------------------------------------|---------------------------------------|---------------------------------|--------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|
| | 7 | | Decedent's Name (First, Middle, | Last) | | | | | 2. Date of | of Death | | 3. Time of Death |
| | Physici /Medic | | Garlan | nd | Lee | | Dicken, | Jr. | Noven | _ | 1 2005 | 1655 ^M |
| | Examin | | 4a. Facility Name (If not institution, | | ımber) | | 4b. City, Town, | | f Death | 4 | c. County of Death | |
| KI | | 100 | 13500 Winchester 5. Social Security Number | er Road Sex | 7. Age (In yrs. | last hirthday) | Cumbe: | | 24 Hrs. 8 Date of | of Birth | Allegany | lace (State or Foreign |
| | Funeral Director | | 206-48-7883 | 1\ M 2□F | 34 | Yrs. | Months Day | | Min. (Mont) | of Birth n, <i>Day</i> , Yea 1/1971 | Maryla | itry) |
| 1 | ס | | Usual Residence of Decedent | | 40- 0 | | | | | | | |
| | show | ٦Ľ | 10a. State 10b. County | ما مساء ماء | 100.0 | ity, Town or Lo | | | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | 28a-1 | Director | Virginia Fre | derick | | | Winchest | er | | 10g (| Citizen of What Cour | 71 |
| | 3a or | ۵ | 2432-203 Berry | villo Pika | , | | | 603 | | | USA | , |
| | death | Funeral | 11. Marital Status | | edent Ever in t | | Was Decedent of | Hispanic Orio | gin? (Specify Yes o | r No- | 14. Race - Americ Black, White, | |
| 36 | within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f show the Marical Exeminer must be maillied at | by Fu | 1 Never Married 2 X Married | 1 ☐ Yes If Yes, G | 2 X No ive | | 1 □ Yes 2🖔 N | | , r conto rnoun, oto | ., | Specify: | |
| 21215-0036 | hours tural | ed b | 3 ☐ Widowed 4 ☐ Divorced | Year or I | Dates: | 16a Decer | ient's Usual Occ | ination | | 16h | Kind of Business/Inc | White |
| 7 | nin 72 | Completed | (Specify only highest Elementary/Secondary (0-12) | grade completed |) (1-4or 5+) | (Give | kind of work don DO NOT use retii | e during most | of working | 100. | Title of Desiriossini | 30317 |
| 2 | od with | Com | 12 | College | | | Laborer | | | Hea | ting & Air | Conditioning |
| Maryland | be file | Be | 17. Father's Name (First, Middle, La | _ | | D: 1 | C | | r's Name (First, Mi | | , | |
| 7 | hould d Men marke matic | ٦ | Garland 19a. Informant's Name/Relationship | Lee | | Dicken, | | | evieve | Dais | y She | eetz |
| S S | th an Ith an 27 is it | | Kelley A. Dicken / | | | | | | ke, Winches | | | (000) |
| ē, | s 1 ar | | 20a. Method of Disposition | | 20b. | | sition (Name of natory or other p | | Date | | Location - City or To | wn, State |
| altimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show amproving the mary filery or other traumatic event, the Medical Examiner must be maillist at ance. | | 1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | State | | Crematory | 1 | 1/03/2005 | Cur | mberland, Ma | aryland |
| Balt | permit. Deperting Imports any Inforce. | | 21. Signature of Funeral Service Li | censee | , | 22 | | | | - | uneral Home, | |
| | 0.D = 6 0 | | 23a. Part1. Enter the disease, or co | adon | saveed the dea | th. Do not not | | | | | Maryland 2 | |
| | | | shock, or heart failure. List or | ty one cause on | each line. | . Do not ent | er trie mode of dy | ring, such as t | cardiac or respirate | ny arrest, | | Approximate Interval Between Onset and Death |
| 10 m | Physician /Medical | | disease or condition resulting in death) | aDue to | (or as a conse | uence of): | | | | | | |
| | Examiner | | Conventially line conditions | h | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | |
| | p # | lner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to | (or as a conse | quence of): | | | - | | | |
| | xecute and II-tran | хагл | Cause (Disease or injury that initiated events resulting in death) Last | c | (or as a conse | quence of); | | | | | | |
| 8760, | icate be executed physicien and s the burial-transit | dical Examiner | | d | | | | | | | | |
| 9 | rtificat ng phy as th | 0 | 15.55.44.5 | | | | | | | | | |
| 30X | ath ceatendir | an/h | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | utcome of pregn birth 2 ☐ Fet | | Ectopic pregnan | су | | | 23d. Date of delive | ry Day Year |
| o. | the e | ysic | 1 Yes 2 No | 4∏Preg 9□ Unki | nant at time of a | death 5□ | Other (specify) | | | _ | WOTH | Day Fear |
| Division of Vital Records, P.O. Box | Attending Physician: The law requires thet the death certif rotath. actorath. actorath. by the funeral director, page 2 should be detached for use a by the funeral director. | by Physician/M | Part II. Other significant condition | s contributing to | death but not re | sulting in the u | nderlying cause g | iven in Part I. | 23e. | Did tobacco | use contribute to th | e cause of death? |
| rds | quires en sign uld be | | | | | | | | | 1 ☐ Yes | 2 <mark>X</mark> No 3□ Prob | ably 4 □Unknown |
| eco | law re as bee | Completed | | | | | | | | Was an | 24b. Were auto | osy findings available inpletion of cause of |
| <u> </u> | The cate h | Соп | | | | | | | 1)X | performed? | death? | 2 No |
| Vita Vita | ician certific ector | Be | 25. Was case referred to medical examiner? | Hospital: | | | | ther | of Death (Check o | | | |
| ō | r this | ٦. ح | 1 Yes 2 No 27. Manner of Death | 28a. Date | of Injury | ER/Outpatien | 1 3 DOA | 4 🗆 Nui | rsing Home 5 1 | | 6 Other (Specify | Scene |
| on | nding ath. r: Afte e fune | atlor | 1 □Natural 5 □ Pending 2 □ Accident investiga | 1 | nth, Day Year) | Injury | 28c. lnj W 1 | ork? ⊒Yes 2 /∑ k | o Subje | it he | raged su | F |
| <u>×</u> | r Atte | Certification; | 3 Suicide 6 ☐ Could no 4 ☐ Homicide determin | t be 28e. Plac | 11 | nome, farm, str | et, factory, office | ÷ | 28f. Locati City o | on (Street a | and Number or Rura | l Route Number, |
| | ital o urs eft ral Di | | | | | wood. | | | 13500 is | in ches | Fer Rd, Cun | sterland, MD |
| | Hosp 24 ho Fune stely fi | edical | 29a. Certifier 1 Certifying (Check only 2 Medical Ex | aminer: On the | e best of my kn basis of examin nner stated. | owledge, death ation and/or in | occurred at the restigation, in my | time, date and opinion, deat | d place, and due to h occurred at the t | the cause me, date a | (s) and manner as st nd place, and due to | ated. the cause(s) |
| | To the Hospital or Attending Physician: The Iwithin 2 Hours effor dash. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Med | 29b. Signature and title of certifier | and ma | | | 29c. Licer | nse number | | 29d. D | ate signed (Month, i | Day, Year) |
| } | 2 | | > 7 chiu | uo? | AR / | | OC | ME | | Nov | member, 2, | 2005 |
| - | | | 30. Name and address of person w | | ise of death (Ite | m 23a) (Type, | | | | | | |
| | na | | ZABIUCA 31. Date filed (Month, Day, Year) | | Regist I's Sign | atura | - | enn St | reet Bal | timor | e, Maryla | nd 21201 |
| | Sta Registr | | | 4 2005 | Blat s | ature 2 | Sparke | • | | | | |

| | | | For State Registrar | S | tate o | of Ma | ryland | | artment rtificate | | | ınd M | lental Hy | giene Reg. No.2 | 05 | 38098 |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------------------------|----------------------|------------|----------------------------|-----------------------------------------|------------------|---------------|-----------------|---------------------------------------|------------------------------|----------------------------------------------------|----------------------------------------------|
| | (a) | | Decedent's Name (First, Middle | , Last) | | | | | | | | | 2. Date of Dea | | Vasa | 3. Time of Death |
| | Physicia /Medic | | Hazel | | Mar | ie | | | Deffen | baugh | 1 | | Month | Day OL | Year OS | 11:00 AM |
| | Examin | | 4a. Facility Name (If not institution | , give stre | et and nu | ımber) | | | 1 | | Location o | f Death | · · · · · · · · · · · · · · · · · · · | 4c. Count | y of Death | |
| | | 200 | SACRED HEA | RT H | IOSP | TI | AL | | Ci | dne | | 7 | | ALI | EGI | YNI |
| ^ | Funeral | | 5. Social Security Number | 6. Sex | 2 🔯 F | 7. Age | (In yrs. I | ast birthday) | If Under Months | 1 Year Days | If Under: | 24 Hrs. Min. | 8. Date of Birt (Month, Da | h y, Year) | 9. Birthp | lace (State or Foreign |
| | Director | | 217-30-1501 | M | 2 JAJ F | 90 | | Yrs. | | | | | 04/16/1 | | Penns | ylvania |
| | and W | } | Usual Residence of Decedent 10a. State 10b. County | | | | 10c. City | , Town or Lo | cation | | | | - | | 1 | 0d. Inside City Limits |
| | anyli eho | 2 | | legany | | | , | | Vale | | | | | | | 1 ☐ Yes 2√ No |
| | 28a-i | Director | 10e. Street and Number | regarry | | | | | 10f. Zip | Code | | | | 10g. Citizen of | What Cour | ntry? |
| | with be or | Ö | 917 Forest A | venue | | | | | | | 21502 | | | USA | | , |
| | ne 23 | era | 11. Marital Status | | Was Dec | edent Ev | ver in U. | S. 13. | Was Deced | | | gin? (Sp | ecify Yes or No | - 14. Ra | ce - Americ | an Indian, |
| 9 | should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other then "natural", or lieme 23e or 28s-f show marked other then "natural mast be rotified at impatt the rotified at | / Funeral | 1 Never Married 2 Marr | ied | Armed F 1 Yes If Yes, G | orces? | | | If Yes, spec 1 ☐ Yes 2 | | n, Mexican | , Puerto | ecify Yes or No- Rican, etc.) | Speci | ack, White, | |
| 215-0036 | ural', | d by | 3 ¼ Widowed 4 □ Divorced | | Year or [| Dates: | | | | | | | | | W | hite |
| Ϋ́ | "nat | Completed | 15. Deceden (Specify only highe | | |) | | (Give | dent's Usua kind of wor DO NOT us | k done d | durina mosi | of work | ing | 16b. Kind of I | Business/In | dustry |
| | withir | E D | Elementary/Secondary (0-12) | | College | (1-4or 5+ | •) | | wner | 9 /9///90 | " | | | Boout | v Shor | |
| N | Hygie ther nt, II | | 17. Father's Name (First, Middle, | Last) | | | | | wiiei | | 18. Mothe | r's Nam | e (First, Middle, | | 7 | |
| Maryland 21 | ed ital | To Be | _ | dam | | | Lep | lev | | | Cora | | Elizabe | | Getz | |
| چ | 2 should and Men is marke aumatic | 1 | 19a. tnformant's Name/Relations | hip (Type, | Print) | | | | ng Address | (Street | and Numbe | r or Run | al Route Numbe | or, City or Town | , State, Zip | Code) |
| Σ | ath a | | Phillip Deffenbaug | n / son | n | | | 918 F | orest A | Avenu | ie, LaV | ale, | Mary land | 21502 | | |
| altimore, | es 1 au of Hea of Hea of Item r othe | | 20a. Method of Disposition | | | | 20b. P | ace of Dispo | osition (Nam | e of | (e) | - | Date | 20c. Location | - City or To | own, State |
| Ë | | | 1 🕅 Buriat 2 □ Cremation 4 □ Donation 5 □ Other (S | | oval from | 1 State | | Vet. Ce | | | 1 | 1/07/ | 2005 | Flints | tone, | Maryland |
| a E | permit. Pag Department Importent: I any Injury o | | 21. Signature of Funeral Service | Licensee | | | | 2 | 2. Name and | Addres | ss of Facilit | у Ас | lams Fami | | | |
| Ö | Depa Impo any Ir | | Kulut C. | 41 | | 1 | | | 404 De | ecatu | ır Stre | et, (| Cumberland | d, Maryla | and 21 | 502 |
| 8760, | death certificate be executed Examiner and eattending physician and dor use as the burial-transit | dical Examiner | 23a Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a b | Due to | (or as a | consequ | e V uence of): | | | | | In La | | | Approximate Interval Between Onset and Death |
| 9 | tificat ng phy as th | Medi | 15.551441.5 | | | | | | | | | | | | | |
| .O. Box | that the death certifice hed by the attending ph detached for use as to | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. | | birth 2 nant at t | Fetal | death 3 | □Ectopic pro □ Other (spe | | ′ | | | | ate of deliver | ery Day Year |
| Records, P. | 8 50 | þ | Part II. Dither significant condition Acute Cap | ons contrib | outing to | eath but | t not resu | Iting in the \mathcal{S} | | use giv | en in Part I | | 23e. Did to | | | ne cause of death? |
| 00 | w require s been si | jete | Acordic 5 | Len | 051 | 3 | | | | | | | 24a. Was | | . Were auto | psy findings available |
| | The lay te has age 2 | Completed | 101105- | Lho | 14 | - 11 | ~L - | Call | 401 | | | | autop perfo | rmed? | prior to co death? 1 \(\subseteq \text{Yes} | mpletion of cause of |
| ta | stcian: Th certificete rector, pag | 0 | 25. Was case referred to medica | t | () | 7 00 | | 411 | 010 | | 26. Place | of Deat | h (Check only o | 2 RNo | 1 103 | - |
| > | yslci is cer direc | To B | examiner? 1 ☐ Yes 2 ☐ No | Hos | pital: | Inpatien | t 2 🗆 | ER/Outpatie | nt 3 DO | A Oth | 0.00 | | ome 5 Resid | | ther (Specif | y) |
| Division of Vital | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely fitted in by the funeral director, page | | 27. Manner of Death 1. Natural 5 Pendii 2 Accident investi | ng | 28a. Date | | , | 28b. Time of Injury | of 2 | Bc. Injur Wor | | | 28d. Describe I | | | |
| <u>Nisi</u> | I or Attendi after death. Director: A I in by the fu | ertification: | 2 Accident Investi 3 Suicide 6 Could 4 Homicide determ | not be | | e of Inju | | me, farm, st | | | | | 28f. Location (S City or Tox | Street and Num vn, State) | ber or Aura | I Route Number, |
| | ospital or A hours after uneral Dire ly filled in by | O | 29a. Certifier 1 Desttifyi | o Physici | | | | | th oppured t | at the ter | no data an | d place | and due to the | aguag(a) and a | | Inted |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | edicai | (Check only 2 Medical one) | Examiner | : On the | basis of onner stat | examinat | tion and/or in | ivestigation, | in my o | pinion, dea | th occur | red at the time, | date and place | , and due to | the cause(s) |
| | To To Com | Σ | 29b. Signature and title of certifie | 1/1 | | In | 1 | 40 | 290 | . Licens | number | 51 | 35 | 29d. Date sign | ed (Month, | Day, Year) |
| 7 | (| | 30. Name and address of person | whacamr | Select Cal | Ise of de | ath (Item | 23a) (Tyna | Print) | <u> </u> | 1 | 1 | 1 | | 1 // | |
| | Thes | | Thomas K | CV | 1agg | /// | m | 0 | 9/2 | 5 | for | . De | - 66 | imbo | Pulan | 1 (M) |
| | Sta Regist | | 31. Date filed (Month, Day, Year NOV 0 7 | 2005 | /32. | egistra | r's Signa | J. A | perte | , | | | | | | |

| | | 1 - For State Registrar | State | of Marylar | • | artmen rtificat | | | | lental H | ygiene Reg. Nø | 200 | 15 | 35000 |
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| Physici /Medio | | Decedent's Name (First, Middle, La Dorothy | Belle | | Dyei | ? | | | | 2. Date of D Month Novem | Day | | Year 05 | 3. Time of Death |
| Examir | | 4a. Facility Name (If not institution, giv 3819 E. 9th Stre | | umber) | | | Town, or | | of Death | | | County | | ert |
| Funeral Director | | 5. Social Security Number 6. S 218–20–8009 | ex □M 2 X F | 7. Age (In yrs. | . last birthday) Yrs. | If Under Months | | If Unde Hours | r 24 Hrs. Min. | 8. Date of B (Month, D Sept | Day, Year) | 20 | | elace (State or Forei etry) Ware |
| the Maryland 28a-f show | Director | Usual Residence of Decedent 10a. State 10b. County Maryland Carol 10e. Street and Number | ine | | ity, Town or Lo | | Code | | | | 10a. Cit | izen of W | | 0d. Inside City Limit 1X Yes 2 □ N |
| 3a or | D | 110 Wheeler Dri | W.A. | | | | 639 | | | | U.S | | nat oour | 10 y 1 |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By any injury or other traumatic event. The Medical Examiner must be notified at ance. | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced | 12. Was Der Armed F | 2X No | | Was Dece | dent of Hi cify Cuba | spanic O n, Mexica Specify | in, Puerto | ecify Yes or N Rican, etc.) | | 14. Race | , White, | an Indian, etc. ite |
| within 72 hou ene. than "nature he Modical E | Completed | 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) | ide completed | (1-4or 5+) | life. | dent's Usu: kind of wo DO NOT u | ork doné d se retired, | luring mo | st of work | ing | | ind of Bus | | · |
| filed Hygid | ပိ | 17. Father's Name (First, Middle, Last, |) | | se se | amsti | . 688 | 18. Moth | er's Name | e (First, Middl | | ufac Surname | | ng |
| should be and Mental marked matic ev | To B | Thomas Jefferso | | nore | 19b. Mailir | na Address | (Street a | | | el Dono | - | | | |
| 1 and 2 s Health ar em 27 is | | Jonna L. Heacoc | | | | E. 9t | h St | reet | Nort | h Beac | h, M | ary1 | and : | , |
| vermit. Pages Department of Important: If it iny injury or o | | 1 XBurial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif | y) | 1 State | ensbor | o Cem | eter | у | 11/20 | 0/05 | | | , | Maryland |
| permil Depar Impor any ir | | 21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com | - Fr | w | F | O_Box | e an | d He _Gre | lfent ensbo | ein Fu | 216 | 1 Hot 39 | ne, | PA |
| Cate be executed / Medical Examiner but streams it the partial-transit | dical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that intitated events resulting in death) Last | b. Due to | Metas o (or as a consection) of (or as a consection) | quence of): | | Pan | C/K4 | tic | Ca | 100 | | | Onset and Death |
| death certifi e attending od for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 🗆 Live | utcome of pregn birth 2 Pet gnant at time of nown | al death 3 | Ectopic pi Other (sp | | | | | | 23d. Date Mon | | ory Day Year |
| w requires that been signed by should be deta | by | Part II. Other significant conditions of | contributing to | death but not re | sulting in the u | nderlying c | ause give | en in Part | I. | | tobacco u | | | e cause of death? |
| The lay | Completed | | | | | | | | | per | s an opsy formed? | pr de | ere autorior to consath? | osy findings available pletion of cause of 2 No |
| Physician: Th rthis certificate ral director, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2500 | Hospital: | Inpatient 2 | TER/Outpation | ıt 3⊡ D0 | Othe | - | | n <i>(Check only</i> me 5 √ Res | | | /0 | |
| 5 6 | H- | 27. Manner of Death Natural 5 Pending Accident investigatio | 28a. Date (Mo | | 28b. Time of Injury | | 8c. Injury Work | | | 28d. Describe | | 6 Other | | " |
| To the Hospital or Attending within 24 hours after death or To the Funerel Director: After completely filled in by the fune to the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the funerel birds or the fune | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | e 28e. Plac | e of Injury - At h | nome, farm, str ify) | eet, factory | y, office | | | | (Street an own, State | | r or Rura | l Route Number, |
| he Hospi n 24 hour ne Funer pletely filk | Medical (| 29a. Certifier Certifying Ph (Check only one) Certifying Ph 2 Medical Example (Check only one) | niner: On the | e best of my kn basis of examin nner stated | owledge, deatl ation and/or in | n occurred vestigation | at the tim | e, date a pinion, de | nd place, a | and due to the ed at the time | e cause(s) , date and | and man I place, ar | ner as st | ated. the cause(s) |
| To the To the comp | Ň | 29b. Signature and title of certifier | 11 | 17 | | 290 | c. License | number | | | | | | Day, Year) |
| | | | /7 | | | | 03 | 312 | 3_ | | / (| -16- | 08 | |
| | | 30. Name and address of person who Jonathan Lowe | | | m 23a) (Туре, О_Ноѕрі | | Road | Pri | nce 1 | Freder | ick. | MD | 2067 | 8 |
| Sta Registi | | 31. Date filed (Month, Day, Year) | | Registrar's Sign | | borti |) | | | | , | | | - |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4 BERTHA ANNA MAE DUFFY 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONM 59/15641 PONINGUIA MPAICA COMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗓 F 214-24-2343 Director Feb. 3, 1907 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a 10607 Flower Street USA 4. Race - American Indian, death Funeral 21811 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 內 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 ☐XNo ģ Specify: 3 Nidowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Itam 27 ie marked other then "na eny injury or other traumatic event. Ita Mental 2006. Elementary/Secondary (0-12) College (1-4or 5+) 8th Seasonal laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John ပ္ Marv Purnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hazel D. Briddell/daughter 10607 Flower Street - Berlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Calvary Ch. Cem. 11/11/2005 Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signatur of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21801 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Se /Medical Due to (or as a consequence of): Examiner ulcers month Decubitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indicated events Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mon 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1□ Yes 2000 To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 41211 Jack my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Formando Acls 3001 Canoll Street Sterbery mal 31. Date filed (Month, Day, Year)
NOV 0 8 2005 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Box 68760.

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Division of Vital Records, P.

Goods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Dix Sr. Richard Franklin 02 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center ninsula WICONICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11/8/1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 12 M 2□F 71 228-48-5305 Yrs Director Virgínia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov or other traumatic event, the Madical Examiner must be nutified at 1 Tyes 2 No Funeral Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21804 USA 120 Coulbourne Dr. 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: δ Specify. 3 Widowed 4 Divorced white "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Dapartment of Health and Mental Hygiene. Importent: if Item 27 is marked other than 's marked other than 's marked other than 'any Injury or other traumatic event, the Machan Elementary/Secondary (0-12) College (1-4or 5+) Carolina Trailways Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Merrill Lee Dix Emily Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn J. Dix/wife 120 Coulbourne Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 11/7/05 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility. Holloway Funeral Home Professional Association A Javid Momosmo 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner s uentally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificete hes al director, page 2 autopsy performed? 1∐ Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2.₩ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō lospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier ş 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2001

Registrar

State

21215-0036

Maryland

Baltimore, I

Box 68760.

P.O.

of Vital

Division

Salisbury,

DIO Miltord St.

MD

21804

30. Name and address of person who completed cause of death (Ite and a) (Type, Print)

100

32. Signature

L

8 2005

NOV 0

31. Date filed (Month

| | | - | For State Registrar | State of Maryl | - | artment of H | | Mental Hygie Reg. | 2000 | 38102 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------|--------------------------------------------------|
| | St. 8 | ý. | 1. Decedent's Name (First, Middle, La | ist) | | | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | Physicia /Medic | | Lloyd | Charles | | Files | | NOVEMBER | 08, 2005 | 2210 ^M |
| 1 . | Examin | - | 4a. Facility Name (If not institution, given | | | - /- | r Location of Death | | 4c. County of Dea | |
| | | de la | Memorial Hospi 5. Social Security Number 6.5 | | yrs. last birthday) | CUMBERL If Under 1 Year | AND If Under 24 Hrs. | 8. Date of Birth | ALLEGAN | |
| * | Funeral Director | | | 1⊠M 2□F 83 | Yrs. Yrs. | Months Days | Hours Min. | (Month, Day, Ye 01/09/1922 | Mary | thplace (State or Foreign |
| at a | \$. | | Usual Residence of Decedent | | | | | 101/03/1322 | maty | Land |
| | how | | 10a. State 10b. County | | . City, Town or Lo | | | | | 10d. Inside City Limits |
| | Ba-f s | Director | MD Allega | ny | Cun | berland | | | | 1 ☐ Yes 2 ☑ No |
| | with the | Dire | 10e. Street and Number 12005 Amber Dr | ivo S F | | 10f. Zip Code 21.5 | in 2 | 10g. | USA | ountry? |
| | eath v | erai | 11. Marital Status | 12. Was Decedent Ever | in U.S. 13. \ | | lispanic Origin? (Sp | pecify Yes or No- | 14. Race - Ame | erican Indian, |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, I're Medical Exertinal Line Lines and once. | by Funeral | 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | Armed Forces? 1 X Yes 2 ☐ No If Yes, Give | | f Yes, specify Cub 1 ☐ Yes 21 No | an, Mexican, Puerto Specify: | Rican, etc.) | Black, White | white |
| Ö 2 | 72 ho | Completed | 15. Decedent's E (Specify only highest gr | | 16a. Deced | dent's Usual Occup | pation during most of work | kina 16t | o. Kind of Business | /Industry |
| 2 | ithin ne. | npie | Elementary/Secondary (0-12) | College (1-4or 5+) | life. I | DO NOT use retire | d) | | | |
| 2 | filed w Hygier other th | | 12 17. Father's Name (First, Middle, Las | 4 | Qualit | y Control | | ne (First, Middle, Mai | Paper | |
| Maryland | i be fi | Be | Chester | | Files | | Edith | | Wolford | |
| Ž | should the market umatic | ဥ | 19a. Informant's Name/Relationship | | | ng Address (Street | | ral Route Number, Ci | | Zip Code) |
| | and 2 : ealth ar n 27 is ser trau | | Charles S. Abell / | nephew | 820 N. | Atlantic | Avenue, Coc | oa Beach, Fl | lorida 329 | 31 |
| re, | s 1 au of Hea item othe | | 20a. Method of Disposition | 20 | Db. Place of Dispo | | STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY | | . Location - City or | |
| Ë | Pages nent of I ant: If its | | 1 ☐ Burial 2 ☒ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec | | Cumberland | , | | /2005 Cu | mberland. | Maryland |
| Baltimore, | permit. Departn Imports any inju | | 21. Signature of Funeral Service Lice | A.D. 1 | | | | ms Family Fu Cumberland, N | | |
| | * 1- × | | 23a. Part1. Enter the disease, or cor shock, or heart failure. List only | nplications that caused he cone cause on each tine. | death. Do not ent | er the mode of dyn | ng, such as cardiac | or respiratory arrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | /10 | essis | in | Yall. | In M | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a cor | sequence of): | 0 | · war | | | 111 |
| | Lxammer | _ | Sequentially list conditions, | b. Due to (or as a con | apels | | | | | 6 day |
| | pet | nine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Bue to (or as a co) | Tourse | n / | Colita | 0 | | 12 dalla |
| | icate be executed physiclen and s the burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to (or as a cor | nsequence of): | -) | Carrie | | | co crego |
| 8760, | e be crisicient | dicai | (| d | | | | | | 7 |
| 9 | tificat ig phy as th | edi | | | | | | | | |
| Вох | death certific e attending p ad for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time | Fetal death 3 | Ectopic pregnanc Other (specify) | у | | 23d. Date of de Month | livery Day Year |
| P.O. | 0 0 0 | ysid | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9☐ Unknown | | | | | | |
| | w requires that been signed b should be deta | ام ا | Part II. Other significant conditions | contributing to death but no | t resulting in the u | nderlying cause gr | ven in Part I. | 23e. Did tobac 1 ☐ Yes | 11 | o the cause of death? |
| Division of Vital Records, | The law requires that the site has been signed by the bage 2 should be detache | Completed | | | | | | 24a. Was an autopsy performed 1 Yes 2 12 | prior to | utopsy findings available completion of cause of |
| ta | an:] tificat tor. p. | a | 25. Was case referred to medical | 1. | | | 26. Place of Dea | th Check only one) | 110 10: | 2 110 |
| <u> </u> | Physician: rthis certifica ral director, i | To B | examiner? | Hospital: 1 papatient | 2 ER/Outpatier | nt 3 DOA | her: 4 🗆 Nursing H | ome 5 Residenc | e 6 □Other (Spe | ecify) |
| 0 0 | ng Ph fter th meral | | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Yea | ar) 28b. Time o | f 28c. Inju Wo | ry at rk? | 28d. Describe how | injury occurred | |
| sio | Attending in death. Sector: After by the fune | cati | 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not | he | | |]Yes 2 □No | | | |
| Divi | al or At after d I Direct d in by | Certification: | 4 Homicide determine | | At home, farm, sti pecify) | reet, factory, office | | 28f. Location (Stree City or Town, S | er and Number or H State) | urai Houte Number, |
| | To the Hospitel or Attending Physicien: The fav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 | edical C | 29a. Certifier 1 Certifying F (Check only one) | Physician: To the best of my aminer: On the basis of exa and manner stated. | y knowledge, deat mination and/or in | h occurred at the ti vestigation, in my | me, date and place opinion, death occu | , and due to the caus rred at the time, date | se(s) and manner a and place, and du | s stated. e to the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | //// | mr | 29c. Licen | se number | 29d. | . Date signed (Mon | th, Day, Year) |
| , | 5/1UA | | / Lul | 1/m | 1111) | D: | 5011/ | 70И | VEMBER 9 | , 2005 |
| کری | 14 | | 50. Name and address of person who | completed cause of death | | 1 | A | A . | | |
| ス | \(\) | | Kenneth Ko | 32. Rigistrar's S | GOO Me | morial | Avenue | Lumb | erland, M | laryland 21502 |
| | Sta Regist | | NOV 1 0 2 | | M. A. | ande | | | | |
| | | | | 100000000000000000000000000000000000000 | | market state of market | | | | |

| | | | For State Registrar | Stat | e of Mar | yland / Dep <i>Ce</i> | artment e <i>rtificate</i> | | | nd Mer | | ene g. Nø. N | 0.5 | 201 | 0.0 |
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| | | | Hegistrar Decedent's Name (First, Midd | lle, Last) | | | ,, imoure | 0. 0 | - Cati | 2. | Date of Death | 4.0 | 149- | 3. Time of | Death |
| | Physici | | Norma Mary | Foster | | | | | | N | Month Ovember | Day | 2005 | 0527 | М |
| | /Medic Examin | | 4a. Facility Name (If not institution | | nd number) | | 4b. City, 1 | Town, or L | ocation of D | | | | unty of Death | | |
| | | · | Carroll Hospi | tal Cent | er | | 1 | Westn | ninste | er | | (| Carrol1 | L | |
| | Funeral | | 5. Social Security Number | 6. Sex 1 ☐ M 25 | | In yrs. last birthda | /) If Under Months | 1 Year Days | If Under 24 Hours | Hrs. 8. Min. | Date of Birth (Month, Day, | Year) | Cor | place (State or intry) | Foreign |
| | Director | - | 218-18-4090 | 1 I M 2 2 | 4' | 80 Yrs. | | | | | eb 08 | 1925 | 5 | MD | |
| | and and | | Usual Residence of Decedent 10a. State 10b. Count | / | 1 | Oc. City, Town or | ocation | | | | | | T | 10d. Inside Cit | y Limits |
| | Mary fied | for | MD (| Carroll | | Mod | tminste | ٥r | | | | | | 1 🗆 Yes | 2 X No |
| | r 28e | Director | 10e. Street and Number | ALLULI | | MES | 10f. Zip | | | | 10 | g. Citizen | of What Cou | intry? | |
| | th wit | a D | 3725 Ridge Roa | ad | | | | 2115 | 57 | | | U | JSA | | |
| | ems ems | Funeral | 11. Marital Status | Arm | Decedent Eved Forces? | er in U.S. 13 | . Was Deced | ent of Hisp ify Cuban, | panic Origin , Mexican, P | n? (Specify Puerto Rica | Yes or No- | | Race - Amer Black, White | | |
| 36 | 72 hours after death with the Maryland "netural", or Items 23a or 28e-f show official Examiner must be notified at | by Fu | 1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce | If Ye | Yes 2 □ No es, Give | | 1 ☐ Yes 2 | ZNo. | Specify: | | | Sp | ecify: Wh | ite | |
| 21215-0036 | houn tural' | ed b | | nt's Education | r or Dates: | 16a Dec | edent's Usua | I Occupati | ion | | 1 | 6h Kind | of Business/li | | |
| 5. | in 72 n "nat | Completed | (Specify only high | est grade comple | | (Gi | e kind of wor DO NOT us | k done du | | f working | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| 212 | filed within Hygiene. other than " | E O | Elementary/Secondary (0-12) | Con | ege (1-4or 5+) | | Homer | naker | <u>-</u> | | | Ow | n Home | • | |
| | be filed within 72 ha ital Hygiene. id other than "natu event, Italia is | Bec | 17. Father's Name (First, Middle | , Last) | | | | 1 | 18. Mother's | s Name (Fi | rst, Middle, M | laiden Sui | mame) | | |
| ylaı | should be filed ind Mental Hygi s marked other umatic event, I | 인 | (unknown) R | ussell | | | | | | | unknov | | | | |
| Maryland | 2 m m | | 19a. Informant's Name/Relation Henry W. Foster | | | | _ | | | | oute Number, Inster, | | own, State, Zi 21157 | p Code) | |
| | 1 and 2 Health tem 27 | | 20a. Method of Disposition | L/IIusbar | IG. | 20b. Place of Dis | oosition (Nam | ne of | | Date | - | | ion - City or T | own, State | |
| 5 | Pages nent of I int: If its iry or o | | 1 Surial 2 □ Cremation 4 □ Donation 5 □ Other (| | from State | cemetery, c | ematory`or ot Branch | | | 11/1 | | | | er, MD | |
| Baltimore, | - E 25 - 5 | 1 | 21. Signature of Funeral Service | | | | | | - | | and Cha | | | W. , 110 | |
| Ã | Departing the particular permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permits and permi | (fb | Mark | 2l | <u></u> | | | | | | Westmi | | | 21157 | |
| | | | 23a. Part1. Enter the direase, t shock, or heart failure. Lis | or complications | that caused the | ne death. Do not e | nter the mode | of dying, | such as ca | rdiac or re | spiratory arre | st, | | Approximate Interval Bety | veen |
| | Physician | 2.55 | Immediate Cause (Final disease or condition | | | stime | 140- | 1 | Fui | 1-12 | | | | Onset and D | eath |
| | /Medical Examiner | | resulting in death) | D. D. | ue to (or as a | consequence of): | | | | | | | | 771 | |
| | LAGITITIE | _ | Sequentially list conditions, | b | uo to /os as a | consequence of): | | | | | | | | | |
| | pet nsit | nine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | ₹ | 00 to (01 a3 a t | consequence on, | | | | | | | | | |
| | execunand and all-tra | Examiner | that initiated events resulting in death) Last | c | ue to (or as a | consequence of): | | | | | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | dicai | | | | | | | | | | | | | |
| 9 | tificat og phy as th | ledi | | 1 | | | | | | | | | | | |
| Вох | leath certific attending p | an/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | s, outcome of Live birth 2 | | □Ectopic pre | egnancy | | | | 23d | . Date of deliv | | 'ear |
| - | ne dea the at hed fo | Physician/Me | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | Pregnant at tir Unknown | me of death | Other (spe | ecity) | | · · · · · · · · · · · · · · · · · · · | | | INIONITY | Day | σαι |
| P.0 | that the deed by the detached | | Part II. Other significant condit | ions contributing | n to death but | not resulting in the | underlying ca | use given | in Part I. | | 23e. Did toba | acco use | contribute to | the cause of de | eath? |
| Records, | signed be det | Completed by | Newsomys | / | | 16-26 | , , | | | | | s 2□N | | . / | nknown |
| Ş | w requir been si should | ete | | | | | | | | | 24a. Was an | 2 | 4b. Were aut | opsy findings a | available |
| Re | sician: The law certificate has t irector, page 2 s | d mo | | | | | | | | - | autopsy perform | ed? | prior to or death? | ompletion of ca | use of |
| <u>ra</u> | an: T tifficate or, pa | e Cc | 25. Was case referred to medic | al | | | x | | 26 Place of | f Death /C | 1 ☐ Yes 2 heck only one | No | 1 🗆 Yes | 2□ No | |
| of Vital | Physician: r this certifica ral director, I | 0 B | examiner? 1 Yes 2 No | Hospital: | 1 Inpatient | 2 ER/Outpat | ent 3 DO | | | | 5 Resider | | Other (Spec | ify) | |
| 101 | | n: T | 27. Manner of Death 1 ☑ Natural 5 ☐ Pend | 28a. | Date of Injury (Month, Day) | (ear) 28b. Time | | Bc. Injury a Work? | at | | . Describe how | | | | |
| Š | Attendir death. ctor: Af y the fu | atic | 2 Accident inves | tigation | | | М | | es 2 □ No |) | | | | | |
| Division | or Att | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter | mined 28e. | Place of Injury building, etc. | y - At home, farm, (Specify) | street, factory | , office | | 28f. | Location (Str. City or Town, | | umber or Rui | al Route Numi | ber, |
| | pitel ours a erai D | | CO- Contine 1 Continu | ing Physician | To the best of | mu kasudadas da | ath conversed | at the time | data and a | nlana and | due to the co | /-> | d | ntate d | |
| | To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Atte completely filled in by the fune | Medical | | I Examiner: On | | my knowledge, de xamination and/or ed. | | | | | | | | | } |
| | vithin To the | Me | 29b. Signature and title of certif | ier | | | | License (| | | 29 | d. Date s | igned (Month | , Day, Year) | |
| | ./1. | | > Roda | 1 No | in , | MO | 6 | 035 | PPZ | | | 11/ | 1/05 | | |
| | Mar | | 30. Name and address of perso | n who completed | d cause of dea | 1 | | | Cent | / | 1 | 0 | / / | | 2 > > |
| | . ,/ | 75 | , , | Mas | | 1 2 | 11,70 | <i>()</i> | (414 | f | D1. 1 | (P1/1 | 1.54 7.3 | 50, 1/16 | 21130 |
| | Sta Regist | | 31. Date filed (Month, Day, Yea | 9 2005 | 32. Registrar | _ | | | | | | | | | |
| | ricgist | ui | NOV | J 7003 | JURIL | w th | asself | 1 | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 5:45A M November Charles Edward Greene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Nursing & Rehab. Ctr. Sykesville Carroll 6. Sex 1 ★ M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 80 Maryland 213-24-7825 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic evant, the Medical Examiner rount be notified at 1 XYes 2 No Maryland Carroll New Windsor Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2818 Carlisle Dr. 21776 U.S.A. or itams 23a Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or items 23 ury or other traumatic event, its Worlicel Examination or other traumatic event, its Worlicel Examination or other traumatic event, its Worlicel Examination or other traumatic event, its Worlicel Examination or other traumatic event, its Worlicel Examination or other traumatic events. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farmer dairy 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be L. Earl Green Susan Katherine Strine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2818 Carlisle Dr. Marjorie M. Greene/wife New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. Pipe Creek Cemetery 11/7/2005 4 ☐ Donation 5 ☐ Other (Specify) nr. Linwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lice 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailue Eugestein **Physician** Hear 148ar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4☐Pregnant at time of death P.O. the be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ enaturo Dourente 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s 1 Yes 2 4No 1 Yes 2 40 the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | ENursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 \ Homicide within 24 hours a To tha Funarai C filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WIL ralle 12005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 ELDORSBURG /URNUS 1000 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 8 2005 Registrar

| | | ŀ | 1 - For State Registrar | State of | Marylan | | artmen rtificat | | | ınd M | | giene Reg. No | 2000 | 38105 |
|------------|-----------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------|-------------------------|--------------------|--------------------|---------------------|-----------------|---------------------------------|------------------|----------------------------|----------------------------------------------------|
| | Physici | an. | Decedent's Name (First, Middle, Las | ") | | | | | | | 2. Date of Dea | | | 3. Time of Death |
| | /Medic | al | Patricia 4a. Facility Name (If not institution, give | street and numb | | ouise | | Town | Location of | 4 | November | 4, | 2005 County of Dea | 10:15 P M |
| To a | Examin | ier | St. Vincent dePaul | | | | 40. Olly, | Frost | | Dodui | | 40. | Allegar | |
| | Funeral | 5. € Ii | Social Security Number 6. Se | | Age (In yrs. | last birthday) Yrs. | If Under Months | r 1 Year | If Under 2 Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Day | y, Year) | | rthplace (State or Foreign country) |
| * | Director | Ì | 217-28-7555 Usual Residence of Decedent | A | 72 | rrs. | | | | | 08/01/1 | 933 | | yland |
| | arylanc ahow | _ | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | the Ma | Director | MD Allegany | <i>r</i> | | | Cumb | erlan | ıd | | | 10a Cit | izen of What C | 1 √ Yes 2 No |
| | 3a or | וום | 1520 Oldtown Ma | mor | | | TOI. ZIE | | 21502 | | | rog. Cit | USA | ountry? |
| | ems 2 | Funeral | 11. Marital Status | 12. Was Decede | | .S. 13. | Was Deced | | | gin? (Spe | cify Yes or No- Rican, etc.) | - | 14. Race - Am Black, Wh | |
| 36 | 72 hours after deeth with the Maryland Insturel', or Items 23a or 28s-f ahow desal Examiner must be motified at | by Fu | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Tyes 2 If Yes, Give Year or Date | ∑ No | | 1 🗌 Yes | | Specify: | | , , , , , , , , , | | Specify: | |
| 21215-0036 | 72 hours "naturel", idical Ex | | 15. Decedent's Ed | ucation | | 16a. Dece | | | | -4 - 4: | | 16b. K | ind of Business | White s/Industry |
| 218 | l within 72 ho iene. r than "natur tha Medical | Completed | (Specify only highest grad | College (1-4 | or 5+) | life. | DO NOT u | se retired | luring most) | of workii | ng | | | |
| d 21 | be filed writel Hygier of other the | e Cor | 12 17. Father's Name (First, Middle, Last) | | | | Home | maker | 18. Mother | r's Name | (First, Middle, | Maiden | Homemal Sumame) | ker |
| lan | ed al | 0 | | som | Lin | naweaver | | i | Mary | | | izabe | | Klosterman |
| Maryland | and and series | | 19a. Informant's Name/Relationship (7 | ype, Print) | | 19b. Mailir | ng Address | (Street a | | r or Rura | l Route Numbe | | _ : | |
| | 1 and 2 Health tem 27 other tra | | Patricia L. Dicks / d | auchter | 20h P | 12905 Place of Dispo | | | e Drive | | mberland, | | y land 2 | |
| Baltimore, | | | 1XXBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, | | ite C | Mary's | natory or c | ther place | . | 1/08/: | | | | |
| altir | 그 돈 돈 글 | | 21. Signature of Fune al Service Licens | | U. | , | | , | | | ns Family | | | Maryland e, P.A. |
| Ö | Depa Depa Impo any ir | | * Kelut Co | sela. | me | | | | | | Cumberlan | | | • |
| | Physician | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition | lications that cau | sed the death | h. Do not ent | er the mod | le of dying | such as o | cardiac o | r respiratory ar | rest, | 7 | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or | as a conseq | uence of): | | | // | 1 1 | von | U | V | Junyo |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or | as a conseq | uence of): | - | | | | | | | |
| | death certificate be executed e attending physician and sd for use as the buriat-transit | Examine | Cause (Disease or injury that initiated events resulting in death) Last | c | as a consequ | uance of): | | | | | | | | |
| 8760, | sician buria | dlcal E | | d | as a consequ | derice or). | | | | | | | | |
| 9 | tificate ng phy as the | ledic | | d | | | | | | | | | | |
| Вох | ath certific attending p for use as | lan/N | JF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcom 1 ☐ Live birth | me of pregna | death 3 | Ectopic p | | | | | | 23d. Date of de | elivery Day Year |
| 0. | 5 ÷ č | Physiclan/Me | 1 ☐ Yes 2 🕱 No 9 ☐ Unknown | 4∐ Pregnan 9∐ Unknow | t at time of de | eath 5 | Other (sp | ecify) | | | | | WOTE | Day |
| <u>α</u> | res that the igned by be detact | by Ph | Part II. Dther significant conditions co | ntnbuting to deat | h but not res | ulting in the u | nderlying c | ause give | en in Part I. | | 23e. Did to | bacco u | use contribute t | o the cause of death? |
| Records, | w requires that been signed b should be deta | ted b | | | | - | | | | | 1 🗆 Y | 'es 2 | □No 3□P | robably 4 Unknown |
| ecc | law as b | Completed | | | | | | | | | 24a. Was a autop | sy | prior to | utopsy findings available completion of cause of |
| Vital F | ate pa | e Cor | Of Manager referred to madical | | | | | | | | | 2 No | death? | |
| Ξ | 9 9 | To Be | 25. Was case referred to medical examiner? | Hospital: | atient 2 🗌 | ER/Outpatien | t 3[] DC | Othe | | | (Check only or ne 5 ☐ Resid | | 6 ∏Other (Spe | acify) |
| n of | ng Phy (fer this | | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of I (Month, | njury Day Year) | 28b. Time of Injury | 2 | 8c. Injury Work | at | | 8d. Describe h | | | |
| Division | Attending r death. sctor: After y the fune | Icatl | Accident investigation 3 ☐ Suicide 6 ☐ Could not be | 28a Place of | Injuny - At ho | omo form etc | M | | /es 2 □N | | 19f Location (S | Strant an | d Number or F | ural Route Number. |
| Ρ | P di C i | Certification: | 4 Homicide determined | 28e. Place of building | etc. (Specify | y) | eer, ractory | , once | | | City or Tow | | | urar noute wumber, |
| | Hospital | edical C | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam | sician: To the be | est of my kno | wledge, death | occurred | at the tim | e, date and | place, a | nd due to the o | cause(s) | and manner a | s stated. |
| | To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by | Medi | one) 29b. Signature and title of certifier | and manner | stated. | alor allogor site | | c. License | | | | | te signed (Mon | |
| | 1 3 1 8 | |) (1/h | M | | | | 010 | CUP | 42 | | | 0 | |
| • | 71. | | 30. Name and address of person who co | ompleted cause of | of death (Item | n 23 2) (Type, | Print) | /() | 76 | / | / | VOL | EMPLLES | 5,2005 |
| | MLS | | Shin Kim, M. | | | et, West | | rt, M | 2156 | 2 | | | | |
| | Sta Registr | - | 31. Date filed (Month, Day, Year) NOV 0 7 200 | 327 Reg | istrar's Signa | J. Ap | arte | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** Marjorie W. Handschumacher Nov 5 2005 12:50PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CUMBERLAND ALLEGANY MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Days 219-14-7000 1 ☐ M 2 🛣 F 80 Yrs 11-13-1924 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Allegany Director Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1532 Old Town Manor Rd., Apt 2 C 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: ģ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Drug Store Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George W. Shroyer Sarah Goldie Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 Cassell Blvd., Prince Frederick, MD 20678 Richard M. Nixon. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Porter Cemeteru 11-8-2005 Hundman. PA 21. Signature of Figural Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hyndman. PA Approximate Interval Between 30nsel and Death Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Due to (or as a consequence of):

Coronary artery disease 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Onknown Fractured hip 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed

Physician /Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed the

Funeral

Director

in then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene important: if item 27 is marked other then "nat any injury or other traumatic event, the Mediciona.

with the Maryland

hours after

Saltimore, Maryland 21215-0036

detached signed by the funeral director, page 2 should be certificate has this Certification: After after death. filled in by

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

24 hours a

within 24 ho To the Fune completely fi

25. Was case referred to medical examiner Teleased Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Yes 2 No

and manner stated

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

28a. Date of Injury Oct (Mooth, Day5 ear) 1 : PMury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Cumberland nursing home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 512 Winiferd Rd Cum

1 Yes

patient fell

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

NOV 0 8 2005

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

1 Natural

25 Accident

3 Suicide

29a. Certifier

Medical

4 - Homicide

29c. License number D003328U 29d. Date signed (Month, Day, Year) Nov 2005

30. Name and address of person who co in leted cause of death (Item 23a) (Type, Print)

Kent Avenue ite 101 Cumberland, Maryland 625 Dr. Sunil Gupta 31. Date filed (Month, Day, Year) 🛮 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death NOVEMBER B, 2005 **Physician** HENRY SHAEFFER HOOK 5:36 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESTMINSTER NURSING/CONVALESCENT CTR CARROLL WESTMINSTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APRIL 5,1918 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∏M 2□F Months Days Hours Yrs. Director 219-05-8591 87 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a Madical Examinar must be notified at 1√XYes 2 □ No Director MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 52 WEST GREEN STREET 21157 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after un and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: WHITE ₩Widowed 4 Divorced Year or Dates: WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) OWNER/OPERATOR TRACTOR SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSE REBECCA SHAEFFER WALTER RAYMOND HOOK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum once. C. CASSANDRA MILLER/DAUGHTER 50 WEST GREEN STREET, WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SOUTH CARROLL CREMATORY 11/12/05 WINFIELD, MARYLAND 22. Name and Address of Facility
MYFRS-DURBORAW FUNERAL HOME, P.A.
91 WILLIS STREET, WESTMINSTER, 21. Signature of Funeral Service Licensee 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Mnknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 IMO Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: 1 □ Yes 2 ⊡ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 5 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a 1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier Nou aclo 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRus 291 STONER AVENUE STE 203, WESTMINSTER, MD 21157 BINU T. CHACKO M.D. 31. Date filed (Month, Day, Year) 32. Registres Signature State NOV 1 0 2005 ▶ Registrar

| | | | For | | Maryland / D | epartment o | nk. Ensure A | - | _ | 38108 |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------|------------------------------------------------|--------------------------------------------------|
| | | V) | State Registrar 1. Decedent's Name (First, Middle, | astl | | Certificate of | of Death | 2. Date of Deat | eg. No. | 3. Time of Death |
| 83 | Physici | _ | JOHN WILLIAM | , | | | | | ER ^{□a} 6, 20085 | |
| 1 | /Medi Examir | | 4a. Facility Name (If not institution, FUTURECARE @ CH | | | | rn, or Location of Death REISTERSTOWN | 1 | 4c. County of Dea | |
| | Funeral Director | | 219-14-8265 | .Sex 7.7 | Age (In yrs. last birti 81 | hday) If Under 1 Y Months Da | ear If Under 24 Hrs. ays Hours Min. | 8. Date of Birth Month Day JANUAR | Y ^{9a()} 4,1924 | thplace (State or Foreign PENNSYLVAN) |
| | Maryland a-f ehow ilied at | tor | Usual Residence of Decedent 10a. State MARYLAND CAR | ROLL | 10c. City, Town | or Location | | | | 10d. Inside City Limits 1 ☐ Yes 2XXIIo |
| | with the 3s or 28s | i Director | 10e. Street and Number 750 PLEASANT VAL | LEY ROAD | | 10f. Zip Co 21 | 1158 | 1 | 0g. Citizen of What Co UNITED ST | |
| 920 | s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene Health and Menial Hygiene item 27 is marked other then "natural", or iteme 23s or 28s-1 show other traumatic event, the Medical Example moral be notified at | by Funerai | 11. Marital Status 1 Never Married Marrie 3 Widowed 4 Divorced | 12. Was Deceder Armed Force 1 | s? 7]No | 13. Was Decedent If Yes, specify 1 ☐ Yes ♣♥ | of Hispanic Origin? (Sp Cuban, Mexican, Puerto (No Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Ame Black, Whi Specify: WH | te, etc. |
| 21215-0036 | within 72 ho ene. then "natur ne Medical | Completed | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 | | | Decedent's Usual O (Give kind of work d life. DO NOT use n | one during most of work etired) | ing | 16b. Kind of Business | /Industry |
| | 12 should be filed within "h and Mental Hygiene." 7 is marked other then "traumatic event, Inc. Me. | To Be Co | 17. Father's Name (First, Middle, Law WILLIAM HARRISON | | | | 18. Mother's Nam | e (First, Middle, E | | |
| Maryland | nd 2 shou Ith and M 27 Is mar | | 19a. Informant's Name/Relationshi | | | | reet and Number or Rui | | , City or Town, State, MINSTER, M. | |
| Baltimore, | Pages 1 and 2 nent of Health i ant: If item 27 I ury or other tre | | 20a. Method of Disposition XXX Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specific Properties) | | cemeter | Disposition (Name of the Country), crematory or other EW MEMORIA | r place) | | 20c. Location - City of | Town, State MARYLAND |
| Baltii | permit. Pages Department of Important: If is eny injury or once. | | 21. Signature of Funeral Service L | | au - | | ddress of Facility RBORAW FUNE S ST WESTM | | , P.A. MD 21157 | , |
| | Physician /Medical | | 23a. Parti. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Finat disease or condition resulting in death) | a | sed the death. Do not ine. | tymple | dying, such as cardiac | | | Approximate Interval Between Onset and Death |
| 68760, | tificate be executed by the physician and as the burial-transit | cal Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | с. | as a consequence of | | | | | |
| .O. Box 68 | attendir for use | by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | 2 Fetal death t at time of death | 3 □Ectopic pregr 5 □ Other (specr | | 47.5 | 23d. Date of de Month | ofivery Day Year |
| ۵. | w requires that the de been signed by the a should be detached | | Part If. Other significant condition | Abontributing to death | h but not resulting in | n the underlying caus | se given in Part I. | 4 | bacco use contribute t es 2 □ No 3 □ F | |
| Records, | has he 2 | Completed | | Hodunp | holus | | | 24a. Was a autop: perfor 1 🗆 Yes | sy prior to death? | utopsy findings available completion of cause of |
| Vital | Physician: The this certificate ral director, pag | Be (| 25. Was case referred to medical examiner? | Hospital: | | | Other | th (Check only or | | |
| of | ng Phys fter this meral dii | tlon: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig | 28a. Date of I (Month, | njury 28b. | | Injury at Work? | | ence 6 □Other (<i>Sp</i> ow injury occurred | ecify) |
| Division | e Hospital or Attending 24 hours after death. • Funeral Director: After letely filled in by the fune | Certification: | 2 Accident investig: 3 Suicide 6 Could n 4 Homicide | ot be 28e. Place of | Injury - At home, fa , etc. <i>(Specify)</i> | ırm, street, factory, o | | 28f. Location (S City or Tow | treet and Number or F n, State) | Rural Route Number, |
| | Hospita 24 hours Funeral etely filled | dicai C | 29a. Certifier 1 Certifying (Check only 2 Medical 6 one) | Physician: To the be xaminer: On the basi and manner | s of examination an | e, death occurred at t d/or investigation, in | the time, date and place my opinion, death occu | , and due to the or rred at the time, o | ause(s) and manner a date and place, and du | es stated. |

W-JL

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)
NOV 0 8 2005

027569

29d. Date signed (Month, Day, Year)

21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended item #20b per fh/wiche tificate of Death 1-7-05/dls Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Louise Harcum Mary 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO TENINSULO REGIONAL MEDICAL 50/15b4 M Centy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 1 F 220-12-0477 Director 5/1/1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or iteme 23s or 28s-f ebow other traumatic event, it a Madical Examinar must be notified at 1 ☐ Yes 2 € No Directo Maryland Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10720 Snethen Church Rd. 21837 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education 12 4+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 end 2 should be Heelth and Mental E. Linwood Davis Dora Ellen Shocklev ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10720 Snethen Church Rd., Mardela Springs, MD 21837 19a. Informant's Name/Relationship (Type, Print) W. Blan Harcum Sr./husband item 27 Baltimore, 20b Place of Disposition (Name of Base (Innuito along or other place)

Beechwood Farms 20a, Method of Disposition 20c. Location - City or Town, State Pages permit. Pages Depertment of Important: If it any injury or o ö 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/7/05 4 ☐ Donation 5 ☐ Other (Specify) Mardela Springs, MD Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association and M. CFSP 501 Snow Hill Rd., Salisbury, MD 21804 422 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician METAGATIC OVAT.AN YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine this certificate has been signed by the attending physicien and al director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 - NO 2 No 1 ☐ Yes : After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 029168 Delitale. 05 M.D.

State Registrar

31. Date filed (Month, Day DHMH 17 Rev 1/2001

5.

Lowell

DIVISION ST. SALISBURY MD

1346

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

7 2005

ALLEN

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| | | | For 1_ State | | | Departme | nt of Health and te of Death | d Mental Hy | giene | 20110 |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------|--------------------------------------|------------------------------------------------------|-----------------------|-------------------------|---------------------------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle | (net) | | Certifica | le of Dealif | 2. Date of De | Reg. No. | 3. Time of Death |
| | Physi | cian | | | IIo | | | Month | Day Year | |
| | /Med | | Roy 4a. Facility Name (If not institution | T. | | rsman 4b. City | y, Town, or Location of D | | 4c. County of De | |
| | Exam | iiner | <u> </u> | NOI Medi | , , | te l | SALISHIM | | Woom | 100 |
| | Funera | al | 5. Social Security Number | 6. Sex 7 | . Age (In yrs. last | birthday) If Under | er 1 Year If Under 24 Is Days Hours N | Hrs. 8. Date of Bir | th 9. B | irthplace (State or Foreign Country) |
| | Directo | | 220-26-1996 | 1 X M 2□ F | 78 | Yrs. | S Days Hours N | | | aryland |
| 0 1 | p > | 1. | Usual Residenca of Decedent 10a, State 10b, County | | 10c City To | own or Location | | | | 10d. Inside City Limits |
| 3 | anyla shov | 5 | , | miao | | isbury | | | | X □Yes 2□No |
| 1 | the M | ect | Maryland Wicc | HILCO | Sai | - | ip Code | | 10g. Citizen of What (| Country? |
| 3 | with | 급 | 1305 Emerson | λιιο | | | 21801 | | USA | |
| 220-26-1991 | 5-0036 72 hours after death with the Maryland natural', or Hems 23a or 28a-1 show disal Exercirent reveal be notified at | by Funeral Director | 11. Marital Status | 12. Was Deced | dent Ever in U.S. | 13. Was Dec | edent of Hispanic Origin becify Cuban, Mexican, P | ? (Specify Yes or No | | nerican Indian, |
| 29 | or Her chart | 표 | 1 Never Married 2 Marr | Armed Fore ied 1 1 Yes 2 If Yes, Give | 2 🗌 No | | 2 X No Specify: | uerto Hican, etc.) | | |
| N | 21215-0036 od within 72 hours aft giene. or than "naturat", or , the Medical Exacult | | 3 Widowed 4 Divorced | Year or Da | tes: Navy | 10 103 | 2 to 140 3 pecily. | | Specify: | white |
| | 5-0 72 hc | Completed | 15. Deceden (Specify only higher | t's Education st grade completed) | 10 | Sa. Decedent's Us (Give kind of y | vork done during most of | working | 16b. Kind of Busines | ss/Industry |
| 7 | within ene. | E E | Elementary/Secondary (0-12) | College (1- | 4or 5+) | `life. DO NOT | t Engineer | | Broadcast | ting |
| 8 29 | d 21 | ပိ | 17. Father's Name (First, Middle, | l ast) | | DLOaucas | | Name (First, Middle | 1 | |
| _ | and be find be code | Be | Charlie C. Hor | | | | | che Richa | | |
| RSMAN | re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Marylan for and 2 should be filed within 72 hours after death with the Marylan from 27 Is marked other than "natural", or thems 23s or 28s-f show other traumatic event, the Medical Exercities must be notified at | ٦ 2 | 19a. Informant's Name/Relations | hip (Type, Print) | 1 | 9b. Mailing Addre | ess (Street and Number o | r Rural Route Numb | er, City or Town, State | , Zip Code) |
| 2 | Ma nd 2 s lith an 27 is | 1 | Oneita M. Hors | | | 1305 Eme | rson Ave., | Salisbury | , MD 21801 | |
| 5 | Baltimore, Mc permit. Pages 1 and 2 Department of Health a Important; if item 27 is any Injury or other trai | | 20a. Method of Disposition | | ceme | of Disposition (Natery, crematory of | lame of r other place) | Date | 20c. Location - City | or Town, State |
| 08 | Dage ent of hit; If | | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | state I | sbury Cr | | 1/9/05 | Salisbur | y, MD |
| 1 | Baltimore, bermit. Pages 1 ar Department of Hea mportant; if Item any Injury or othe | ej . | 21. Senature of Funeral Service | | | 22 Name | and Address of Facility | Home Pro | fessional | Association |
| | W FRE | ä | In Ha | Man | | 201 2 | SHOW LITT KO | ., Salisi | oury, MD 21 | .804 |
| | | | 23a. Part. Enter the disease, or shock, or heart failure. List | complications that can | sused the death. Dach line. | o not enter the m | ode of dying, such as car | diac or respiratory a | rrest, | Approximate Interval Between |
| | Pnysicia | 1000 | Immediate Cause (Final disease or condition | | | | EMBOL1. | | | Onset and Death |
| | /Medic | al | resulting in death) | | or as a consequen | | | | | 100000 |
| | Examine | | Sequentially list conditions. | b | | | | | | |
| | P # | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (c | or as a consequen | Bei off)t | | | | |
| | ecute and trans | E | that initiated events resulting in death) Last | c. Due to (| or as a consequen | ca of): | | | | |
| | 760, see executed sician and burial-transit | <u></u> | | | | | | | | |
| | physicate | | | d | | | | | | Y 191 |
| | Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending physion by the funeral director, page 2 should be detached for use as the line by the funeral director, page 2 should be detached for use as the line. | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant | | come of pregnancy | | | | 23d. Date of | delivery |
| | BC Beath atter | clar | in the past 12 months? | 4□Pregna | irth 2 □ Fetal de ant at time of death | | | | Month | Day Year |
| | o.O. It the d | hysi | 9 Unknown | 9□ Unkno | own | | | | | |
| | IS, P.O. res that the de igned by the be detached | by P | Part II. Other significant conditi | ons contributing to de | ath but not resulting | ng in the underlying | g cause given in Part I. | 23e. Did | | to the cause of death? |
| | cords w require been sig | | | | | | | _ 10 | Yes 2⊠No 3□ | Probably 4 Dunknown |
| | BCOF law requast been 2 should | pie | | | | | | 24a. Was | psv prior | autopsy findings available to completion of cause of |
| | The I | Completed | | | | | | perf 1 ☐ Yes | ormed? death | ? es 2□ No |
| | Vital ician: T | Be | 25. Was case referred to medical examiner? | -715 | | | | Death (Check only | one) | |
| | on of Vita ding Physician: After this certific funeral director, | 2 | 1 ☐ Yes 20€ No | - | | /Outpatient 3 | | | idence 6 Other (S | pecify) |
| | Jn C | on: | 27. Manner of Death 1 Natural 5 Pendi | iig . | h, Day Year) | b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | | how injury occurred | |
| | ISIO Itsnd Heath ttor: / | cat | 2 Accident invest | | of Injury - At home | | | | (Street and Number or | Rural Route Number. |
| | or A safter after blrech | Certification: | 4 ☐ Homicide deter | nined 200. Place buildir | ng, etc. (Specify) | , raini, street, raci | tory, omco | | wn, State) | |
| | spital ours a | Ö | | ng Physician: To the | best of my knowle | dge, death occurr | ed at the time, date and p | place, and due to the | cause(s) and manner | as stated. |
| 2 | Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicomolegic willed in by the funeral director, page 2 should be detached for use as the | Medicai | (Check only 2 Medica one) | Examinar: On the ba | asis of examination ner stated. | and/or investigati | ion, in my opinion, death | occurred at the time | , date and place, and o | due to the cause(s) |
| | To the Forthing To the County | Me | 29b. Signature and title pf certifi | | | | 29c. License number | | 29d. Date signed (Mo | |
| | | 3 | 1- Sme | kosy, N | l.D., P | h.D. | D586 | .89 | 11-8-03 | |
| ri, | The | 14 | 30. Name and address of person | who completed caus | e of death (Item 23 | 3a) (Type, Print) | | | | |
| | | 7 | Tom Swierko. | 52 400 E | astern 5/ | here dr | Salisbury, | md. 21 | 803 | |
| | | State | 31. Date filed (Month, Day, Year | 9 2005 32.8 | sistrar's Signatur | e L | / . | | | |
| | Reg | istrar | 1100 | A 5007 | EMEURO R | 7. GOGAR | 2.3 | | | |

| | | | 1 - For State Registrar | State of Marylan | d / Depa | | lealth and N | fental Hygie | 2005 | 38111 |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------------|-------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | 0071 | modic of | Dealit | 2. Date of Death | J. No. | 3. Time of Death |
| | Physici | | Melissa | Cooper J | acksor | า | | November | Day Year | 10. |
|) | /Medic Examin | | 4a. Facility Name (If not institution, give : | | | | r Location of Death | VUYEMSEI | 4c. County of Dea | |
| | ZAGIIIII | | Peninsula Pepins | ral Dedical (| Center | Salie | shurl | | Wicon | |
| Ī | Funeral Director | | 5. Social Security Number 6. Sep 263-55-9940 | | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day,) Dec. 28 | (ear) 9. Bir | thplace (State or Foreign ountry) |
| | and | | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town or Loc | ation | | | | 10d Incide City Limits |
| | d within 72 hours after death with the Maryland Jene. Ir than "natural", or Itama 23a or 28e-1 ahow The Madical Examinar must be incillised at | 호 | Md. Worces | | comoke | | | | | 10d. Inside City Limits 1 X Yes 2 □ No |
| | r 28e | Director | 10e. Street and Number | | | 10f. Zip Code | | 100 | g. Citizen of What Co | ountry? |
| | h witi | 0 | 2367 Ward rd. | | | 2185 | 1 | r | JSA | |
| | dea | ner | | 12. Was Decedent Ever in U. Armed Forces? | S. 13. W | | lispanic Origin? (Sp an, Mexican, Puerto | | 14. Race - Ame | |
| ထ္ထ | or Ita | F | 1 Never Married 2 Married | 1 ☐ Yes 2 ☑ No | | Yes 21 No | | rican, etc.) | Black, Whit | |
| 8 | ural', | d b | 3 Widowed 4 Divorced | Year or Dates: | | | | | Specify: B | lack |
| 7 | "net | lete | 15. Decedent's Edu (Specify only highest grade | cation completed) | 16a. Decede | int's Usual Occup | ation during most of work d) | ing 16 | 6b. Kind of Business | /Industry |
| 21215-0036 | withle ene. then | Completed by Funeral | Elementary/Secondary (0-12) | College (1-4or 5+) | | | " Assista | | Public | School |
| | a training | | 17. Father's Name (First, Middle, Last) | | | | | e (First, Middle, Ma | | 30001 |
| lan | | To Be | Walter Mas | on | | | Rosale | ee J. Co | oper | |
| Maryland | s 1 and 2 should if Health and Men Itsm 27 is marke other traumatic | | 19a. Informant's Name/Relationship (Type | oe, Print) | 19b. Mailing | Address (Street | and Number or Run | al Route Number, (| City or Town, State, . | Zip Code) |
| | and 2 salth n 27 I | | Rosalee J. Mas | on/Mother | 2367 | Ward r | d. Pocor | noke Cit | y,Md.21 | 851 |
| ore | of Head | (C. 2) | 20a. Method of Disposition 1 | amount from State | | atory or other place | e) | | c. Location - City or | |
| Ë | Pages ment of tant: If It lury or o | | 4 □Donation 5 □ Other (Specify) | Ebe | | | | | SnowHill | |
| Baltimore, | permit. Pages Department of Important: If I eny Injury or one | | 21. Signature of Funeral Service Licens | | 22. @ 1 | Name and Addre | ss of Facility Be | ennie Sm reet Po | nith Function | eral Home City,Md. |
| | | | 23a. Part. Enter the disease, or compli- snock, or heart failure. List only on | cations that caused the death | n. Do not enter | the mode of dyin | g, such as cardiac | or respiratory arrest | t, | Approximate |
| 4 | Physician | | Immediate Cause (Final disease or condition | Pheunace | 1 | carinii | preum | | | Intervat Between Onset and De. th |
| | /Medical | | resulting in death) | Du to (or as a conseq | | | | .,,(()- | | 3 weeks |
| м | Examiner | | Sequentially list conditions. | acquired | Immu | ne de | fictency | syndra | ne | |
| | De # | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ | uence of): | | | | | |
| | and I-tran | хап | that initiated events resulting in death) Last | Due to (or as a consequ | ience of): | | | | | |
| 1760, | ate be executed hysicien and the burial-transit | calE | | 200 (0 (0) 23 2 00113041 | 261106 01). | | | | | |
| 687 | ficate p phys | | • | | | | | | | |
| Вох | death certifica a ettending ph id for use as th | ZM. | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregna | ncy | | | | 23d. Date of del | iverv |
| œ. | res that the death certifica igned by tha ettending ph be deteched for use as the | Physician/Med | in the past 12 months? | 1 Live birth 2 Fetal | | ctopic pregnancy Other (specify) | | | Month | Day Year |
| P.O. | at the | hys | 9 Unknown | 9□ Unknown | | | | | | |
| <u>8</u> | igne igne be d | Ď | Part II. Other significant conditions con | tributing to death but not resu | ilting in the und | erlying cause give | en in Part I. | | | the cause of death? |
| oro | w requir been si should | Completed | | | | | | 1 Yes | 2 X No 3 ☐ Pr | obably 4 Unknown |
| Şec Şec | e law has b | npie | | | | | | 24a. Was an autopsy | prior to d | topsy findings available completion of cause of |
| ᇤ | r: Th | | | 2 | | | | performe 1 Yes 2 € | | 2 No |
| Ħ | alciar cartif recto | Be | 25. Was case referred to medical examiner? | ospital: | | 3□ DOA Othe | 26. Place of Death | | | |
| Division of Vital Records, | ding Physician: The lav h. After this cartificate has funeral director, page 2 | ۲. T | 1 ☐ Yes 2 ☑ No '' | 1 X Inpatient 2 ☐ I 28a. Date of Injury | ER/Outpatient 28b. Time of | 3□ DOA 28c. Injury | 4 Nursing no | ne 5 ☐ Residend 28d. Describe how | e 6 ☐Other (Specialistics) | cify) |
| o | Attending of death. actor: After by the funer | tion | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Intury | Work | (? Yes 2 □ No | od. Doscillo now | injury occurred | |
| Visi | Attan r dea actor by the | ifica | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At ho | me, farm, stree | t, factory, office | | 28f. Location (Stree | et and Number or Ru | ral Route Number, |
| ā | Ital or irs efte ral Dir led in | Certification: | | building, etc. (Specify | | | | City or Town, S | | |
| | To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu | edicai | 29a. Certifier 1 X Cartifying Phys (Check only 2 Medical Examinone) | ician: To the best of my know ar: On the basis of examinat and manner stated. | wledge, death o ion and/or inve | occurred at the tim stigation, in my op | ne, date and place, pinion, death occurr | and due to the caus ed at the time, date | se(s) and manner as and place, and due | stated. to the cause(s) |
| | Vith Con | Σ | 29b. Signature and title of certifie | | | 29c. License | | | Date signed (Monti | n, Day, Year) |
| , | | | · Clan | | | D308 | 553 | | 11/2/05 | |
| | | | 30. Name and address of person who con | mpleted cause of death (Item | 23a) (Type, Pr | int) | - 1 | | | |
| | -01 | | Charles B. Silvia J. | Peninsul 32. Registrar's Signat | a Kagia | al Medi | cal Center | - Jalish | wy, md. | 21801 |
| | Sta Registra | | 31. Date filed (Month, Day, Year) | Peninsul 32. Registrar's Signat | K A | ack! | | |) | |

| | | | | | State of Ma | aryland. | • | artment of I <i>tificate of</i> | | Mental Hy | rgiene Reg. No. | 0 = | 201 | 10 |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------|--------------------|----------------------|----------------------------------------|---------------------------------------|-----------------------------|-------------------------------|--------------------------|----------------------------------|---------------|
| п | | | 1. Decedent's Name | e (First, Middle, Las | it) | | | | | 2. Date of D | | <u> </u> | 3. Time of | Death |
| н | Physici | | June | 4 | Lee | | Ki1 | rou | | Month | Day | Year | 0.00 | 2 434 |
| | /Medic Examin | | | | street and number) | | KIĪ | .LOy | 4b. City, Town, or | Novembe Locetion of Dea | | 005 y of Death | 9:09 | AM |
| | Examin | eı | | | Care Center | | | | 01 1 | 1 | | • | | |
| | Funeral | | 5. Social Security N | | | e (In yrs. last | t birthday) | If Under 1 Year | | 8. Date of B | rth | legany 9. Birtho | place (State o | or Foreian |
| и | Director | | 217-18-4147 | 1 | □M 2\\ F | 83 | Yrs. | Months Days | Hours Min | . (Month, D 08/12/1 | | Maryla | place (State ontry) | |
| | | l | Usual Residence of | | | 0.5 | | | | 100/12/1 | , , , , | mary 1 | atto | |
| | ylen Fow | | 10a. State | 10b. County | | 10c. City, T | own or Lo | cation | | | | 1 | 0d. Inside Ci | ty Limits |
| | Ma Person | 호 | MD | Allegar | ıv | | Cumbe | rland | | | | | 1½ Yes | 2 🗆 No |
| | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | <u>a</u> | 10e. Street and Nur | | | | | 10f. Zip Code | | | 10g. Citizen of | What Cour | ntry? | |
| | th wi | al | 23 I | Plymouth Dr | ive | | | | 21502 | | USA | | | |
| | e 2 5 | Funeral Director | 11. Marital Status | | 12. Was Decedent Armed Forces? | Ever in U,S. | 13. \ | Was Decedent of I | Hispanic Origin? (Span, Mexican, Puer | Specify Yes or N | | ce - Americ | | |
| 21215-0020 | permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylend Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at once. | ρ | 1 ☐ Never Marri 3 ☐ Widowed | ed 2⊠ Married 4 □ Divorced | 1 ☐ Yes 2 ☒ If If Yes, Give Year or Dates: | No | 1 | 1 □ Yes 2 🗓 No | | to Ficall, etc.) | Speci | nck, White, fy: Wh | ite | |
| Ŏ | 2 ho | Completed | | 15. Decedent's Ed | ucation | 1 | 6a. Deced | lent's Usual Occu | pation | | 16b. Kind of E | | | - |
| 215 | hin 7 | ple | (Spec | ify only highest gra | de completed) College (1-4or 5 | 54) | (Give life. L | kind of work done DO NOT use retire | pation during most of wo | orking | | | | |
| 2 | d wit | E | 12 | 110419 (0 12) | Conego (1-401 c | , , , | Но | omemaker | | | Homema | ker | | |
| p | othe othe | Be | 17. Father's Name (| (First, Middle, Last) | | | | | 18. Mother's Na | me (First, Middle | , Maiden Surna | | | |
| <u>la</u> | Aenta Aenta rked rked | 2 | Joseph | | М. | Lindn | er | | Elizabe | eth K. | Kn | oche | | |
| Maryland | sho sand N | | 19a. Informant's Na | me/Relationship (7 | ype, Print) | | 19b. Mailir | ng Address (Stree | t and Number or R | ura <i>l Route Numi</i> | per, City or Town | , State, Zip | Code) | |
| | alth a | | Edward C. F | Kilrov / hu | shand | | 23 PI | vmouth Dri | ive, Cumber | land. Mar | vland 21 | 502 | | |
| Sre. | of He Item | | 20a. Method of Disp | osition | | 20b. Place ceme | e of Dispo | sition (Name of natory or other pla | ice) | Date | 20c. Location | · City or To | own, State | |
| Ĕ | Pege int: if | | | S ☐ Other (Specify | Removal from State | | | Crematory | | 11/07/200 | 5 Cumber | land. | MD | |
| Baltimore, | permit. Peges 1 end 2 should be filed withir Depertment of Health and Mental Hygiene. Important: If Item 27 is merked other than any injury or other traumatic evant, tra Mones. | | 21. Signature of Fu | ne al Service Licen | see | | | . Name and Addre | | | ly Funera | | | |
| m | Depe Impo any is | | | 1. x C | Pin. | | | 404 Decati | ır Street, | | | | | |
| | | \dashv | 23a. Part . Enter th | ne disease, or comp | olications that caused | the death. I | | | | | • | | Approximate Interval Bet | е |
| | Physician | | shock, or hear | rt failure. List only | one cause on each lir | ne. | | | | | | | Interval Bet Onset and I | ween Jeath |
| şê. | /Medical | | Immediate Cause (| Final | Ce | rebr | 7 | 0. | Acrido | 1/ | | Į. | 3 Week | les |
| | Examiner | | disease or condition resulting in death) | n | a | Due to (or as | | | -,2(0-0 | | | 1 | | |
| | | Je | | | | 200 10 (01 00 | <i>a</i> | 201100 017. | | | | 1 | | |
| | cuted nd ransi | edical Examiner | Sequentially list cor | nditions. | b | Due to (or as | s a conseq | uence of): | | | | - 1 | | |
| ó | an ar rial-t | Ä | Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events | mediate rlying | | | | | | | | | | |
| 68760, | ysici | Cal | Cause (Disease or that initiated events resulting in death) L | injury | c | Due to (or as | a conseq | uence of): | | | | | | |
| | ng pt | | rosuming in Geam) i | -031 | | | | | | | | 1 | | |
| Вох | th ce endii r use | and | | | d | | | | | | | - | | |
| | dea ed fo | 믕 | Part II. Other signifi | cant conditions co | entributing to death be | ut not resultin | ng in the ur | nderlying cause gi | ven in Part I. | 23b. Did | tobacco use co | ontribute to | the cause o | of death? |
| P.0 | at the by the | 중 | Coror | and a | to al | | | | | 1 | Yes 2 No | 3 ☐ Prol | bably 4 | Unknown |
| Ś | es the | þ | | - Ja | cong ou | 15000 | 21 | | | | | | | |
| Records, | The law requires that the death certificete be executed ete hes been signed by the ettending physician and page 2 should be detached for use es the burral-transit | Completed by Physician/M | 0_ | mat. | | | | | | | s an autopsy ormed? | ava | ere autopsy f ailable prior t | 0 |
| e C | aw n 9s be 2 sh | e l | | The contract | | | | | | | | of | mpletion of c death? | ause |
| | The I | ě | | | | | | | | 10 | Yes 3 No | 1[|]Yes 2□ | No |
| Division of Vital | sician: The law certificete hes b director, page 2 s | Be | 25. Was case referr | red to medical | | | | | 26. Place of De | ath (Check only | one) | 1 | | |
| > | Attending Physician: or death. ector: After this certific by the funeral director. | P | 1 Yes 2 D | No | Hospital: 1 ☐ Inpatie | nt 2□ER | /Outpatien | t 3 DOA Ot | her: 4 Nursing I | Home 5□Res | idence 6 □Otl | ner (Specif | y) | |
| 0 | ig Ph ter th neral | Ë | 27. Manner of Death | n 5 □ Pending | 28a. Date of Inju (Month, Day | ry 28 v Year) | b. Time of Injury | 28c. Inju Wo | ry at | 28d. Describe | how injury occu | rred | | |
| Ö | ath. Pr: Af | 턣 | 2 ☐ Accident | investigation | | | | | Yes 2 □ No | | | | | |
| Σį | r Atte | ≌ | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 28e. Place of Inju- | ury - At home | , farm, str | eet, factory, office | | 28f. Location City or To | (Street and Num wn, State) | ber or Rura | i Route Num | ber, |
| | Ital o | Ce | | | | | | | | | | | | |
| | To the Hospital or Attending Physician: The li within 24 hours effer death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page | edical Certification: | 29a. Certifier (Check only one) | | sician: To the best of iner: On the basis of and manner sta | examination | | | | | | | |) |
| | withir To th | Me | 29b. Signature and | title of certifier | | | | 29c. Licen | se number | | 29d. Date signe | d (Month, | Day, Year) | |
| | 1 | | - | top | tur | | | D332 | 280 | | November | 7, 200 | 05 | |
| | | - | 30. Name and addre | ess of person who | completed cause of d | eath (Item 23 | Ba) (Type. | | | | | , = 3 | | |
| | TLA | | | nil K. Gupt | a, M.D., 62 | 25 Kent | Avenue | e, Cumberla | and, Maryla | nd 21502 | | | | |
| | Sta | е | 31. Date filed (Mont | th, Day, Year) | | ar's Signature | | | , | | | | - | |
| | Registr | | NOV | 0 7 2005 | BURN | 13. | STATE OF | | | | | | | |

DHMH 16 Rev 6/95

| | | 1 | For State Registrar | State of Marylan | | artment of H tificate of I | | | iene g. No. 005 | 38113 | | | |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------|---------------------------------------------|---------------------------------------------|---------------------|-----------------------------------------------------------------|--|--|--|
| | Physicia | ın | I. Decedent's Name (First, Middle, Last) | KIRWAN | / | | | 2. Date of Deat Month | | 3. Time of Death | | | |
| | /Medic Examin | er 4 | a. Facility Name (If not institution, give s | PICEATL | AKE | 4b. City, Town, or SAL | Location of Death 1584XY If Under 24 Hrs. | 2. Data of Righ | 4c. County of I | | | | |
| 80.0 | Funeral Director | 1 | 218-30-1387 | 7. Age (In yrs. | Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, 06-03-1 | 934 TY | Country) (ASKIN, MD. | | | |
| | aryland •how | | Jsual Residence of Decedent 10a. State 10b. County | | y, Town or Lo | | | | | 10d. Inside City Limits 1 X Yes 2 No | | | |
| | h the M | Director | MD WICOMIO | UU I | SALISBU | 10f. Zip Code | | 1 | log. Citizen of Wha | at Country? | | | |
| | th wit | | 906 EMERALD COURT | | | | 21804 | | US | SA | | | |
| | деа пте | Funeral | 11. Marital Status | 12. Was Decedent Ever in U Amed Forces? | | Was Decedent of H | lispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | American Indian, White, etc. | | | |
| 036 | be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "natural", or itame 23a or 28a-f ehow event, the Madical Examiner must be notified at | Ď | 1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced | 1 XYes 2 □ NoARM If Yes, Give Year or Dates 1977 — | Y | 1☐Yes 2☐XNo | Specify: | | Specify: | WHITE | | | |
| Maryland 21215-0036 | in 72 ho n "natul | Completed | 15. Decedent's Edu (Specify only highest grad | e completed) | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most of work | ing | 16b. Kind of Busin | ness/Industry | | | |
| 212 | e filed within at Hygiene. other then vent, the wa | Com | Elementary/Secondary (0-12) | College (1-4or 5+) 2 | UNITE | D STATES | | | MILI | TARY | | | |
| pu | be filed stal Hygi od other event, I | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam LEONA MA | • | | | | | |
| ryla | s 1 and 2 should be f Health and Mental Itam 27 is marked other traumatic ev | P. | MORGAN BAIN KIRWAN 19a, Informant's Name/Relationship (T) | rpe, Print) | 19b. Mailir | ng Address (Street | and Number or Rur | | | ate, Zip Code) | | | |
| | ロモトラ | | AUDREY M. KIRWAN - | | | | OURT, SALIS | | | | | | |
| Baltimore, | of Health of Health f Itam 27 | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F | Computal from State | cemetery, crei | osition (Name of matory or other plac | ce) | | 20c. Location - Cit | | | | |
| ţim | 4 Donation 5 Other (Specify) SPRINCHILL MEM. GDNS. 11-09-2005 HEBRON, MARYLAND 23 Name and Address of Facility, POLINIDS, FILINEDAL HOME, INC. | | | | | | | | | | | | |
| Bal | permil Depar Impor any Ir | Taylor, at the | | | | | | | | | | | |
| | * * | | 23a Part1. Enter the disease, or compleshock, or head failure. List only o | lications that caused the dear ne cause on each line. | th. Do not ent | ter the mode of dyir | ng, such as cardiac | or respiratory arr | rest, | Approximate Interval Between On set and Death | | | |
| | Physician | | | 5.05, 2.0 | | | | | | | | | |
| 1 (1) 26 1 (1) | /Medical Examiner | , | resulting in death) | | | | | | | | | | |
| *** | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a consecution to for a co | | | | | | | | | |
| | ecuted and -transi | Examine | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consec | cuence of): | | | | | | | | |
| 8760, | cate be executed physicien and the burial-transit | dical E | | d | | | | | | | | | |
| 9 | ertifica ling ph e as th | Med | IF FEMALE: | OG Hues auteomo of scare | 0.000 | | | | 00.1 P.11 | 4.45 | | | |
| O. Box | at the death certific by the attending p tached for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 0 9 ☐ Unknown | al death 3[| ⊒Ectopic pregnanc ⊒ Other (specify) _ | у | | 23d. Date of Month | · · | | | |
| <u>α</u> | as the gned | þ | Part II. Other significant conditions co | | sulting in the u | underlying cause gr | ven in Part I. | 23e. Did to | | ute to the cause of death? | | | |
| Records, | The law require te has been si age 2 should t | Completed | | | | | | 24a. Was a autop perfor 1 \(\text{Yes} \) | rmed? dea | re autopsy lindings available or to completion of cause of ath? | | | |
| Vital | | BeC | 25. Was case referred to medical examiner? | 32 | 277 | | 26. Place of Dea | th Check only or | ne | | | | |
| of V | 5 5 2 | 2 | 1 Yes 2 No | | ER/Outpatie | nt 3L DOA | | | dence 6 Other | | | | |
| | ding n. After fune | tion: | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time o | Wo | rk?]Yes 2 No | 20d. Describe II | low injury occurred | | | | |
| Division | l or Attendi after death. Director: A I in by the fu | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At I building, etc. (Spec | | treet, lactory, office | | 28f. Location (S City or Tow | | or Rural Route Number, | | | |
| 1 | To the Hospitel or Attending within 24 hours after death. 710 the Funerel Director: After gompletely filled in by the fune | Medical Co | (Check only 2 Medical Exam | ysician: To the best of my kn iner: On the basis of examin and manner stated. | ation and/or in | nvestigation, in my | opinion, death occu | rred at the time, o | date and place, an | d due to the cause(s) | | | |
| 20 | To the within To the | Me | 29b. Signature and title of certifier | , 5 | | 29c. Licen | se number | | 29d. Date signed (| Month, Day, Year) | | | |
| | 1 | | y amel | W great | و | - T | 714256 | | 11/6/ | 05 | | | |
| | 12/2 | | 30. Name and address of person who of | completed cause of death (Ite | om 23a) (Type | Print) COASI | TAL HOS | DIFICE A | ETCAR | = | | | |
| 7 | St Regist | ate rar | 29b. Signature and title of certifier Council 1 30. Name and address of person who of the second address of person who of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the second address of the seco | 32. Registrar's Sign | M. | poete | , | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** COY Y0 200 /Medical 4c. County of Death Facility Name (If not institution, give street and number, Town, or Location of Death Examiner 1 COMICO 05 isbury Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 2 Hrs Date of Birth (Month, Day, 5. Social Security Number **Funeral** Months Days Hours Min 1 M 2 □ F 72 215-32-5849 Director 1/12/1933 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "naturel", or items 23s or 28s-f show or other traumatic event, its Modical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 E. Mallard Drive 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Sales Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jack Kroll Lena Abelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: if item 27 is eny Injury or other trau Arleen Bloom Kroll/wife 23 E. Mallard Dr., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Arial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery 11/10/05 Salisbury, MD re of Funeral Service Licensee ^{22. Name and Address of Facility}
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cinnec ی/ months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) sete hes been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Funeral Director: , completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

wild E. Counce,

31. Date filed (Month, Day, Year)

MD

4 2005

Salisbury

Bux 1733

cause of death (Item 23a) (Type, Print)

COASTAL

32. Registrar's Signature

| | | - | L_ Stete | State of Maryland / D | Depar | rtment tificate | of H | ealth a | | ental Hy | giene | 005 | 381 | 15 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------|--------------------|--------------------------------------|--------------|--------------------------------------------------|--------------------------|---------------------------------------------|---------------------------------------------|----------------------|
| | | | Registrer 1. Decedent's Name (First, Middle, Last) | | | | | | 2 | 2. Date of Dea | ath | | 3. Time of I | Death |
| | Physicia | an | CHARLES WILLIAM | ALFRED KENWORTH | Y. S | R. | | | | Month 10 | 31 | 2005 | 0715 | \mathbf{A}^{M} |
| , | /Medic Examin | | 4a. Facility Name (If not institution, give str | | | 4b. City, To | own, or | Location o | of Death | | 7 | ounty of Death | 0715 | |
| | _ Admini | • | SPA CREEK CENTER | | | ANNA | POL | IS | | | A | NNE ARU | | |
| | Funeral Director | | 213-14-3664 | 7. Age (In yrs. last bin | | If Under 1 Months | Year Days | If Under: Hours | Min. | B. Date of Birt. (Month, Day 2/24/1 | /, Year) | | place (State or ntry) LNA | r Foreign |
| | pun * | } | Usual Residence of Decedent 10a, State 10b, County | 10c. City, Towr | n or Loca | ation | | | | | | | 10d. Inside Cit | ty Limits |
| | Aaryla r sho | 5 | | | | BEAC | ш | | | | | | 1 ☐ Yes | 2√ No |
| | the h | Director | DELAWARE SUSSEX 10e. Street and Number | KEHUI | ротп | 10f. Zip C | | | | | 10g. Citize | en of What Cou | | |
| | 3e or | | 21 KINGSBRIDGE RO | DAD | | 1 | 997 | 1 | | | u | sa | | |
| 36 | s within 72 hours after death with the Maryland Jiene. I then "netural", or Items 23e or 28e-f show It e Madeal Ext. Inser oust be naiffled a | by Funeral | | . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | 1 | /as Decede Yes, specif | | spanic Ori n, Mexican Specify: | | ify Yes or No- ican, etc.) | | I. Race - Ameri Black, White Specify: | | |
| 8 | hour tural | ed b | 15. Decedent's Educa | | . Decede | ent's Usual | Occupa | ation | | | 16b. Kind | d of Business/Ir | | |
| 15 | n "nel | piet | (Specify only highest grade of Elementary/Secondary (0-12) | Completed) College (1-4or 5+) | (Give k life. Di | and of work O NOT use | done d retired, | turing mosi) | t of working | 9 | | MICAL M | | TUR- |
| 212 | | Completed | Elementary/Secondary (0-12) | | TRAI | NING | SUP | ERVIS | OR | | IN | G COMPA | NY | |
| g | be filed stal Hygid of other event. | Be | 17. Father's Name (First, Middle, Last) | | | | ŀ | 18. Mothe | er's Name (| (First, Middle, | Maiden S | lumame) | | |
| <u>Na</u> | should by | 으 | CHARLES RANDALL | | | | | MAR | | HORTY | | | | |
| Maryland 21215-0036 | 2 2 2 2 C | | 19a. Informant's Name/Relationship (Type | | | | | | | | - | Town, State, Zi | | |
| | s 1 and 2 if Health item 27 other tre | | IRVING RANDALL KEN | WORTHY / SON 2] | | | | E ROA | D, RE | | | CH DE ation - City or T | 199/1 | |
| Ore | m O | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rei | moval from State cemeter | ry, crem | atory or oth | ner place | | | 1 | | | | |
| altimore, | permit. Pag Department Importent: I any injury o | | ' 4 Donation 5 Other (Specify) | BETHEL | | HODIS Name and | | | | 1/04/05 |) L. | EWES, D | ELAWAK | E |
| Bal | permit. Page Department Importent: II any injury o | | 21. Signature of Funeral Service License | M00866 | PA 16 | RSELL 961 K | . FU | NERAL S HIC | HOMI: | ES & CE | DE. | ORIUM 19958 | | |
| | Physician | | 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition | cause on each line. | | the mode | | | cardiac or | respiratory ar | rest, | | Approximate Interval Bety Onset and D | ween |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequence | of): | | | | | | | | , | |
| | LAGITITIE | ٦ | Sequentially list conditions, b. | Due to (or as a consequence | of): | | | | | | | | | |
| | ed isit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence | 01). | | | | | | | | | |
| | be executed sician and burial-transit | xan | that initiated events c. resulting in death) Last | Due to (or as a consequence | of): | | | | | | | | | |
| 760 | siciar buri | caiE | | | | | | | | | | | | |
| 687 | ficate g physics the | | | | | | | | | | - 1 | | | |
| Box. | The law requires that the death certificat the has been signed by the attending phypage 2 should be detached for use as th | Physician/Med | IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | | Ectopic pre Other (spe | | | | | 23 | 3d. Date of deliv Month | * | /ear |
| , P.O | res that tigned by | by Ph | Part II. Other significant conditions conti | ributing to death but not resulting i | in the un | derlying ca | use give | en in Part I | | 23e. Did to | obacco us | e contribute to | the cause of d | eath? |
| rds | quires n sign ald be | d b | | | | | | | | 1 🗆 🗅 | /es 2 □ | No 3□Pro | bably 4 □U | Jnknown |
| Records, | The taw require cate has been single 2 should I | Completed | | | | | | | | 24a. Was autor perfo 1 \(\text{Yes} \) | | 24b. Were aut prior to co death? | opsy findings a completion of ca | available ause of |
| Vital | | BeC | 25. Was case referred to medical examiner? | | | | | 26. Place | of Death | (Check only o | - | | | |
| of V | 0 7 | 10 E | 1 Yes 2 No | spital: 1 Inpatient 2 ER/Ou | utpatient | | | 4 / INL | | | | Other (Speci | fy) | |
| n o | ding Phy h. After thi funeral o | on: | 27. Manner of Death 1 Natural 5 Pending | | Time of Injury | | c. Injun Worl | | | Bd. Describe I | now injury | occurred | | |
| Sio | tendl leath. tor: A | cati | 2 Accident investigation 3 Suicide 6 Could not be | CO. Disease (Jaius) At home (| | M fastani | | Yes 2□ | _ | 9f Location / | Street and | Number or Rui | al Boute Num | her |
| Division | or All | Certification: | 4 Homicide determined | 28e. Place of Injury - At home, fa building, etc. (Specify) | am, sue | eet, ractory, | OHICE | | | City or Tov | | TVB/IIDOF OF FIER | w 110510 115111 | 2011 |
| _ | To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Medical Co | 29a. Certifier (Check only one) 29a Certifying Physical Control (Check only one) | cian: To the best of my knowledger: On the basis of examination are and manner stated. | je, death nd/or inv | occurred a restigation, | it the tin | ne, date ar pinion, dea | nd place, ar | nd due to the d at the time, | cause(s) a date and p | and manner as place, and due | stated. to the cause(s) |) |
| . | To th within To th compl | Me | 29b. Signature and title of certifier | Currer | 1. | 29c. | License | D32 | 1030 | , | 29d. Date | signed (Month | Day, Year) | |
| 7 | 2/3 | | 30. Name and address of person who com | npleted cause of death (Item 23a) | (Туре, Б | Print) | h | The | IM. | Char | ١. ا | 1/7/20 Md2/ | 619 | |
| | シェ | | 21 Date filed (Afeath Day Year) | 32. Registrar's Signature | PIL | J CV VI | 14 | 1007 | 07 | ~ 1W1 | - | | - '/ | |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 1 4 20 | 05 Maria Signature | A | nerth | <i>p</i> | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 NOV-16, **Physician** 10:22A M RISDON KNOTT /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LA PLATA CHARLES 7927 BETHANY LANE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F 87 Director AUG. 30, 1918 WASH. 577-18-9201 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or Items 23e or 28es show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral', or Itams 23e or 28a-f show Exeminer must be notified at 1 ☐ Yes 2 ☑ No LA PLATA Director MARYLAND CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 U.S.A. 7927 BETHANY LANE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2XXX0 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: Completed by WHITE 3℃Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic evant, the Medical 16b. Kind of Business/Industry MARTHA WASHINGTON Elementary/Secondary (0-12) College (1-4or 5+) REST. & MOTEL SECRETARY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANGELA LORETTA JAMESON JOHN FRANCIS RISDON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CYNTHIA STINE-DAUGHTER 7927 BETHANY LANE, LA PLATA, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If it any injury or o SACRED HEART CH. CEM. 11-21-05 LA PLATA, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M0047 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mile of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 0 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Falure **Physician** months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Physician/Medical the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has page 2 1 Yes 2 No 1 Yes 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Medical Certification: After or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C To the Hospital 29a Certifier 1🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and 05)4641 who completed cause of death (Item 23a) (Type, Print) 3 LaPiata MD 20646 Charlene A Letchford MD- 404 Charles St 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

NOV 2 8 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

NOV 0 4 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AMBER /Medical cility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death COMICO 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1□M 2XF 216-56-0919 56 Yrs. Director Sept. 16, 1949 Delaware Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits traumatic event, the Medical Exeminer must be notified at Director MD 1 X Yes 2 ☐ No Wicomico Bivalve 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20840 Nanticoke Road ітете 23а 21814 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked o William Gillis Knowles 2 Helen Pusey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i 38 Mill Chase Circle Douglas E. Jones (Son) Millsboro, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State To I 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: if any injury or sonce. Crematory of Delmarva 11-13-2005 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home Crewel 13 E. Grove Street Delmar, DE 23a. Part1. Enterine disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC BRRAST CARCINOMA MONTHS /Medical Due to (or as a consequence of): Examiner WETASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b rmea? 2 No 200 1 Yes 1 Yes or Attending Physician: director, To Be 25. Was case referred to medical 26. Place of Death (Check only one, 1 Yes Hospital: Cther: 4 Nursing Home 5 Residence State (Specify) H & PIC R 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pendina Injury death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARIS 26266 ARROWWOOD GHU MON CT. SAUSBURY 31. Date filed (Month) V 1 4 2005 State Registrar

| | | | 1 - For Stata Registrar | | Maryland / Dep <i>Ce</i> | artment of H | lealth and M | | ene 0 0 5 | 38119 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------|-------------------------------------------------|----------------------------------------|------------------------------------------------|
| | Physici | | 1. Decedent's Name (First, Middle, Last Hilda Jean Lewi | | | | | 2. Date of Death Month | Day Ye | |
| | /Medio Examir | | 4a. Fecility Name (If not institution, give | | per) | 4b. City, Town, or | Location of Death | | 4c. County of D | |
| | | | Washington County | Hospita | 1 | Hagersto | own | | Washing | gton |
| | Funeral Director | | 190-14-82// | x] M 2∭ F | Age (In yrs. last birthday) 82 ^{Yrs.} | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day,) March 09, | 9. 1923 | Birthplace (State or Foreign Country) MD |
| | land ow | | Usuel Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | Mary e-f sh | tor | MD Washingt | on | Hager | stown | | | | 1 X Yes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | 100 | g. Citizen of What | Country? |
| | s 23a | rail | 333 Mill Street | 10 111 | | 21740 | | | USA | |
| 36 | be filed within 72 hours after death with the Maryland nat Hyglene. sd other than "neturel", or Items 23a or 28e-1 show event, the Medicel Exactive countile of at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date | as? XNo | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏋 No | | ecity Yes or No- Rican, etc.) | Black, W | merican Indian, /hite, etc. |
| Maryland 21215-0036 | 2 hou | ted | 15. Decedent's Edu | cation | 16a. Dece | dent's Usual Occupa | ation | 16 | Sb. Kind of Busine | White |
| 215 | within 7 ene. than "n | Completed | (Specify only highest grad Elementary/Secondary (0-12) | e completed) College (1-4 | life. | kind of work done of DO NOT use retired | turing most of work) | king | | - |
| 2 | e filed wi Il Hygien other th vent, Ille | | 11 | | Home | maker | | | Own Home | 2 |
| and | uld be fi fental H rked of tic ever | Be c | 17. Father's Name (First, Middle, Last) | | | | | e (First, Middle, Ma | , | |
| Z | 2 should by and Menta Is marked sumatic ev | 2 | Emory Thompson 19a. Informant's Name/Relationship (7) | rpe, Print) | 19b. Maili | ng Address (Street a | | arl Mitch | | e. Zip Code) |
| | s 1 and 2 should f Health and Men item 27 Is marke other traumatic | | Barbara E. Ellis/D | aughter | | Shelby C | | stown MD | | , |
| ore, | es 1 a of He fitem r othe | | 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □F | 0 | 20b. Place of Dispo | sition (Name of matory or other place | 9) | | c. Location - City | or Town, State |
| im | Pages ment of tent: If it | | '4 □Donation 5 □ Other (Specify) | | Cedar Gro | ve Christ | ian 11/1 | 6/05 Wa | rfordsbu | ırg, PA |
| Baltimore, | permit. Pages Department of I Importent: If its any injury or of | | 21. Signature of Funeral Service Licens | 99 | | 2. Name and Addres | 7.7 | 1 West Ma | | |
| | 40244 | | 23a. Part1. Enter the disease, or compl | Lavis | Mo14/4 Gr | | | | | 21750-0368 Approximate |
| | Dhusisian | | shock, or heart failure. List only o Immediate Cause (Final | ne cause on eac | h line. | | g, such as cardiac | or respiratory arres | ι, | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a Due to (or | as a consequence of): | | | | | |
| | Examiner | | Sequentially list conditions | D | Corona | ry Ar | tiry | Disce | isl | |
| . / | ed sit | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or | as a consequence of): | +., | . + | E.I | 1.06 | |
| ٧. | ate be executed only sician and the burial-transit | Examine | that initiated events resulting in death) Last | Due to (or | as a consequence of): | Slive | Hearl | rail | W. (| |
| 8760, | e be e sician s burig | | (| 4 | | | | | | |
| 9 | death certificate be executed e attending physician and of for use as the burial-transit | fedical | In service | 4 | | | | | | |
| Вох | leath certific attending pl | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | me of pregnancy 2 Fetal death 3 | Ectopic pregnancy | | | 23d. Date of | |
| O.E | the at | ysici | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnan 9□Unknow | | Other (specify) | | | Month | Day Year |
| P.0. | t th | / Ph | Part II. Other significant conditions co. | ntributing to deat | h but not resulting in the u | nderlying cause give | on in Part I. | 23e. Did tobac | cco use contribute | to the cause of death? |
| Division of Vital Records, | luires tha n signed ild be dei | d by | Diabet | | uclitus | | | 1 ☐ Yes | 2 No 3 | Probably 4 Unknown |
| 00 | | Completed | | | | | | 24a. Was an | 24b. Were | autopsy findings available |
| Re | The tarate ha | omi | | | | | | autopsy performe 1 Yes 2 | d? death | |
| ita | vician: The lav certificate has rector, page 2 | Be C | 25. Was case referred to medical examiner? | | | | 26. Place of Deat | h (Check only one) | | |
| of V | Physician: rthis certificatal director, i | 은 | 1 Yes 2 10 | lospital: | | | 4 Nursing no | me 5 Residenc | | pecify) |
| uc | ding P | tion: | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of (Month, | Day Year) 28b. Time of Injury | Work | at ? ∕es 2 □ No | 28d. Describe how | injury occurred | |
| /isi | l or Attending after death. Director: After I in by the fune | Certification: | 3 Suicide 6 Could not be | 28e. Place of | Injury - At home, farm, str | | 63 2 110 | 28f. Location (Stree | et and Number or | Rural Route Number, |
| á | el or A s after al Dire | Serti | 4 Homicide | building | , etc."(Specify) | ,,,, | | City or Town, S | State) | |
| | To the Hospitel or Attending Physician: within 24 horus after death. To the Funeral Director: After this certific completely filled in by the funeral director. | edical (| 29a. Certifier 1 Certifying Physical Conduction (Check only one) 2 Medical Exemi | sician: To the be ner: On the basi and manner | est of my knowledge, death s of examination and/or in stated. | n occurred at the tim vestigation, in my op | e, date and place, inion, death occur | and due to the caus red at the time, date | se(s) and manner a and place, and o | as stated. ue to the cause(s) |
| | To the withing To the comp | Me | 29b. Signature and title of certifier | | | 29c. License | , | 29d | . Date signed (Mo | |
| | | | > Faire m | mm | | | 50396 | | , , | 4/05 |
| | 3 | | 30. Name and address of person who co | | _ | Print) 1\2 | 6 opa | 1 ct | | – 4 |
| | Sta | to | 21 Date filed (Month Day Veer) | 32. Reg | istrar's Signature | | Ha | 1 ct gerster | IM WE |) 11/40 |
| | Registr | ar | NOV 2 8 20 | 05 | Con H d | See ! | | | | |
| DH | MH 17 Rev 1/20 | 001 | | | ORIGINA | L | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 5

| | | | For Stata Ragistrar | State of Man | yland / | / Departme <i>Certifica</i> | | | nd Me | | gien e . Reg. No. | 005 | 38120 |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------|--------------------------|--------------------------------------------|---------------------------------|----------------------------|-----------------------------|----------------------------------------------------|-----------------------------------------------------|
| 4 | Physici /Medio | cal | 1. Decedent's Name (First, Middle, Last Betty Isabell Myers | | | 45 65 | Town | Lacation of | 1 | Date of Dea Month | ber | 12 24 | 05 11.32 |
| 1. | Examir Funeral | 28°= | 4a Facility Name (If not institution, give Sacred Hear 5. Social Security Number 6. Se | T HOSOI X 7. Age (III | the last | birthday) If Und |) UN eri Year | Location of 2 C/ If Under 2 Hours | lai | Date of Birt (Month, Da | u | County of Dea | Athorized (State or Foreign country) |
| 3 | Director | | 218-12-5400 Usual Residence of Decedent | 81 | | Yrs. | | | | 16-Dec- | 1923 | Ma | ryland |
| | ehow | ō | 10a. State 10b. County | | | own or Location | | | | | | | 10d. fnside City Limits 1 Yes 2 No |
| | ith the Marylar or 28a-f ehow | Director | Maryland Allegar 10e. Street and Number 10502 Pir | iy 15 ney Mountain Ro | Frostb | 104.7 | ip Code | | | | 10g. Citiz | zen of What C | 1 |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "neturel", or items 23a or 28a-f ehow important: If item 27 ie marked other than "neturel", or items 23a or 28a-f ehow propriaty or other traumatic event, the Mudical Examinar funtilised at ODGS. | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 1 | . / | spanic Orig n, Mexican, Specify: | in? (Specif Puerto Ric | y Yes or No- ean, etc.) | | A 14. Race - Am Black, Whi Specify: Wh | ite, etc. |
| 15-0 | "netur | Completed | 15. Decedent's Edu (Specify only highest grad | ucation fe completed) | 1 | 6a. Decedent's Us (Give kind of v life. DO NOT | uaf Occupa | tion furing most | of working | | 16b. Kir | nd of Business | s/Industry |
| 212 | d withir | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) | | homemake | | | | | home | emaker | |
| Maryland | 2 should be fited withir and Mental Hygiene. ie marked other than aumatic event, Lie M. | To Be C | 17. Father's Name (First, Middle, Last) Frank John Felker | | | | | Grace | Lenha | | | • | |
| Mar | id 2 sho lift and 27 ie m | | 19a. fnformant's Name/Relationship (T) Mary Spataro | ype, Print) daughter | | 19b. Mailing Addre 10502 Piney | | -: | r or Rural R Frostb ' | | | Town, State, arvland | Zip Code) 21532 |
| ore, | of Health of Health litem 27 | | 20a. Method of Disposition 1 ★Buriaf 2 □ Cremation 3 □ I | | 20b. Place | Road Riden S | other place | e) (e | Date | | | cation - City o | |
| Baltimore, | permit. Pages Department of I Important: If its any injury or o | | 4 □Donation 5 □ Other (Specify, |) | | rt Cemetery | | | | v-2005 E | Eckhar | t Ma | aryland |
| Bal | permit. Departimonts any inji | | 21. Signature of Funeral Service Licens | mund | 1 | 1 | | s of Facility al Hom | | Frost Av | ve., Fr | ostburg, | MD 215 |
| | Physician /Medical Examiner | | 23a. Part. Enter the disease, or composition, or heart failure. List only of Immediate Cause (Finaf disease or condition resulting in death) | lications that caused the ne cause on each line. a. Due to (or as a co | B | lateral | | g, such as c | | espiratory ar | rrest, | | Approximate Interval Between Onset and Death i week |
| | xecuted and al-transit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a co | | | | | | | | | |
| 8760, | icate be executed physician and s the burial-transit | cal | Ĺ | d | | | | | | | | | |
| P.O. Box 6 | The law requires that the death certificate be executed ate has been signed by the attending physician and bage? should be detached for use as the burial-transit | Physician/Med | fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown | 23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown | ☐ Fetaf de | ath 3 Ectopic | | | | | 2 | 3d. Date of de Month | elivery Day Year |
| | w requires that the bear signed by should be detact | Ď | Part II. Other significant conditions co | entributing to death but noted to the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second construction of the second con | not resultin | P | cause give | | | | obacco u | | to the cause of death? Probably 4 Genknown |
| Il Records, | | Completed | COR pulm | vnole | | | | | | | | 24b. Were a prior to death? | |
| Vital | Physicien: rthis certificated rail director, in | o Be | 25. Was case referred to medicaf examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 Anpatient | 2 □ ⊂ □ | VOutpatient 3 ☐ I | Othe | | | Check only o | | G □Other (Spe | - of the |
| of | Attending Phy or death. ector: After this by the funeral d | atlon: To | 27. Manner of Death Matural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Yo | 28 | Bb. Time of Injury | 28c. Injury Work | 4 1401 | 280 | d. Describe t | | | <i>өсп</i> у) |
| Division | To the Hospitel or Attending is within 24 hours after death. To the Funerel Director: After completely filled in by the funer | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of fnjury building, etc. (| - At home (Specify) | e, farm, street, faci | ory, office | | 28f | Location (S City or Tox | | | Rural Route Number, |
| | To the Hospitel or within 24 hours after To the Funerel Dir completely filled in | Medical | 29a. Certifier 1 Certifying Phyone) 2 Medical Exam | ysicien: To the best of n iner: On the basis of ex and manner stated | camination | edge, death occurre a and/or investigation | d at the timen, in my op | e, date and pinion, death | d place, and h occurred | due to the at the time, | cause(s) date and | and manner a place, and du | s stated. e to the cause(s) |
| | within To th | W | 29b. Signature and title of certifier | | | | 9c. License | | | | 29d. Date | e signed (Mon | nth, Day, Year) |
| | 1 | | 39. Name and address of person who o | omplated cause of doc- | th /ltam or | 3a) (Tuna Print) | 721 | 244 | + | | 11, | /13/2 | -005 |
| 4. | 11 20 | | 30. Name and address of person who of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o | 10701 Ne | Signatur | Seorges | Cres | ekR | d. F | Frost | bur | g, Ma | -005 aryland 21532 |
| | St Regist | ate rar | | 005 | ford a | 15. Thom | | | | | | U | 1 |

DHMH 17 Rev 1/2001

McIntyre, Tasha Baltimore, Maryland 21215-0036

| | | | 1 = State Registrar | State of Ma | | epartment of F Certificate of | | | iene 005 | 38121 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------|----------------------------------------------------------------|----------------------------------------|----------------------------------------|------------------------------------|----------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | th | 3. Time of Death |
| | Physicia | | Tasha Juanita | (AKA: Juan: | ita Melrose | e) McIntyr | e | October | 31, 200F | 10:05AM |
| | /Medic Examin | | 4a. Facility Name (If not institution, give s | treet and number) | | 4b. City, Town, o | r Location of Dea | | 4c. County of Deal | |
| | | | Lions Manor Nursing I | Home | | Cumber | | | Allegany | |
| | Funeral | | 5. Social Security Number 6. Sex | M 257E | (In yrs. last birtho | Months Days | If Under 24 Hr Hours Min | . (Month, Day | Year) 9. Bir | hplace (State or Foreign ountry) |
| | Director | | 215-26-7550 Usual Residence of Decedent | -X | 75 Yr | 5. | | 07/28/193 | 30 Mar | yland |
| | land ow | 1 | 10a. State 10b. County | | 10c. City, Town o | r Location | | | | 10d. Inside City Limits |
| | Mary Interpretation | tor | MD Allegany | | LaVale | 2 | | | | 1 ☐ Yes 2 🛣 No |
| | h the | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What Co | ountry? |
| | th will | | 636 National | Highway | | 2150 | 2 | | USA | |
| | tema tema | Funerai | The trial course | 12. Was Decedent 8 Armed Forces? | | Was Decedent of H If Yes, specify Cuba | lispanic Origin? (an, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | 14. Race - Ame Black, Whit | |
| 36 | or l | by Fi | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced | 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates: | lo | 1 ☐ Yes 2 🖾 No | Specify: | | Specify: | The \$ the o |
| 8 | d within 72 hours after death with the Maryland Jiene. r than "natural", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at | edt | 15. Decedent's Educ | | 16a. D | ecedent's Usual Occup | ation | | 16b. Kind of Business | White Undustry |
| 215 | within 72 ene. than "na he Medii | Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5 | | Give kind of work done fe. DO NOT use retire | during most of we d) | orking | | • |
| 21 | giene. | E O | 12 | Conlege (1 401 3 | */ | Owner | | | Hair Salon | |
| n- | sal Hygie d other event, the | Be (| 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | ime (First, Middle, i | Maiden Surname) | |
| yla | 2 should be and Mental Is marked o | 5 | George | | ookabaugh | | Leona | | Dere | |
| Maryland 21215-0036 | 12 sh h and 7 Is m traum | | 19a. Informant's Name/Relationship (Ty) | oe, Print) | | | | | , City or Town, State, 2 | Zip Code) |
| | is 1 and 2 should be filed of Health and Mental Hyg Item 27 Is marked othe other traumatic event, | | Kyle Bucy / son | | 20b. Place of D | 879 West 67th isposition (Name of | | | 20c. Location - City or | Town, State |
| Baltimore, | permit. Pages 1 Department of H Important: If ite any Injury or ot | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify) | emoval from State | | ciematory or other plac nd Crematory | ^{сө)} 11/1 | | Cumberland, | |
| Ħ | nit. F artme ortan Injur | | 21. Signature of uneral Service License | 90 | Guilberra | 22. Name and Addre | | | y Funeral Hon | |
| ñ | Depa Impo any I | | Low Car | lome | | 404 Decatur | | | Maryland 21 | , |
| | | | 23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on | cations that caused le cause on each lin | the death. Do not | enter the mode of dyir | ng, such as cardia | c or respiratory arr | est, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | | ARCINOM | 4 17 6 | CALAN | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as | a consequence of) | : | | | | 0 10,0 11 |
| | LAdillilei | | Sequentially list conditions, | | * | 200 | | | | |
| | ted nsit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | à consequence of) | | | | | |
| | execunand and al-tra | Xar | that initiated events cresulting in death) Last | Due to (or as | a consequence of) | : | | | | |
| 8760, | death certificate be executed e attending physician and of for use as the burial-transit | dicai E | | l | | | | | | |
| 9 | tificat ng phy as th | Medi | | | | | | | | |
| Box | death certific attending pl | an/N | 23b. Was decedent pregnant | 3c. If yes, outcome 1 ☐ Live birth | of pregnancy 2 □Fetal death | 3 Ectopic pregnance | , | | 23d. Date of del | |
| | e dea the att | Physician/Me | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 4□Pregnant at 9□Unknown | | 5 Other (specify) | | | Month | Day Year |
| P.0 | that the de led by the a detached t | | Part II. Other significant conditions con | tributing to death by | ut not resulting in th | ne underlying cause an | on in Part I | 23e Did tol | bacco use contribute to | the cause of death? |
| ds, | es De | d by | | | | on conjung according | | 1 □ Y | | |
| cor | w requir been s should | iete | | | - | | | 24a. Was a | n 24h Were au | itopsy findings available |
| Record | The lavate has | Completed | | | | *************************************** | | autops | med? prior to death? | completion of cause of |
| Vital | | a | 25. Was case referred to medical | | | | 26. Place of De | 1 ☐ Yes : | 2 No 1 ☐ Yes | 2 No |
| Ž | y S | To B | examiner? 1 ☐ Yes 2 No | ospital: 1 🗌 Inpatie | nt 2 ER/Outp | atient 3 DOA Oth | ar V | | ence 6 Other (Spe | cify) |
| n of | De je od | | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of Injur (Month, Day | y 28b. Tin Year) Inju | | y at k? | 28d. Describe ho | ow injury occurred | |
| sio | Attending Price death. ector: After by the funera | cati | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | | | Yes 2 □ No | | | |
| Division | 47 . 2 2 | Certification: | 4 Homicide determined | 28e. Place of Inju- building, etc | ury - At home, farm c. (Specify) | , street, factory, office | | City or Town | reet and Number or Ru n, State) | iral Route Number, |
| _ | Hospital Pospital Puneral i | | 29a. Certifier 17 Certifying Phys | ician: To the best of | of my knowledge, o | leath occurred at the tir | me, date and place | e, and due to the c | ause(s) and manner as | stated |
| | e Hos | edical | (Check only 2 Medical Examination) | ner: On the basis of and manner sta | examination and/ | or investigation, in my o | pinion, death occ | urred at the time, d | ate and place, and due | to the cause(s) |
| | To the Hospital or a within 24 hours after within 24 hours after To the Funeral Direction of completely filled in b | Me | 29b. Signature and title of certifier | 1 01 | | 29c. Licens | e number | 2 | 9d. Date signed (Mont. | h, Day, Year) |
| | 5 | | Sum V | Imall | NO | 41 | 4205 | 54 C | october 3 | 31, 2005 |
| | ni | | 30. Name and address of person who co | mpleted cause of d | eath (Item 23a) (Ty | /pe, Print) | | | | |
| | MAS | | 31. Date filed (Microsh, Day, Year) | ISON, M | D 91 | a Setun | Dr. C | umberl | ana, Mi | 21502 |
| | Sta Registr | | 31. Date filed (Maph, Day, Year) NOV 0 2 2005 | July 1 | ar's Signature | de | | | | |

| | | | For State | State of Marylan | | artment of H | | d Mental H | 1 | 11115 | 38122 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------|---------------------------------|---------------------------------------------|-----------------------------|----------------------------------------------------|--------------------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Lasi | 1) | Cel | uncate of L | Jean | 2. Date of [| Reg. No: | .000 | 3. Time of Death |
| | Physicia | | | Edward Mar: | ine | | | Nov. | 13. | 2005 | 1:15 P M |
| , | /Medic Examin | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, or | Location of C | | | County of Dea | |
| | Examin | Ϊ. | Chesapeake Woo | ds | | Cambri | idge | | | orche | ster |
| | Funeral | | Social Security Number 6. Se | | | If Under 1 Year Months Days | | Hrs. 8. Date of E Min. (Month, I Aug. | irth Qay, Yea <u>r</u>) | 9. Bird | thplace (State or Foreign puntry) aware |
| | Director | | 220-09-8619 Usual Residence of Decedent | 3xM 2□F 8. | Yrs. | | | Aug. | 26, 19 | 920 De. | Laware |
| | land ow | - | 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | | 10d. Inside City Limits |
| | Mary Ff sh | ţo | MD Dorche | ster | Hu | rlock | | | | | 1 ☐ Yes 2 ☑ No |
| | in the or 28s | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citi | zen of What Co | ountry? |
| | 23e c | rai | 5880 Cloverdal | | | 2164 | | | | ted Si | |
| | tams | Funerai | 11. Marital Status | 12. Was Decedent Ever in U. Armed Forces? | S. 13. | Was Decedent of Hi f Yes, specify Cuba | ispanic Origin n, Mexican, P | ? (Specify Yes or I uerto Rican, etc.) | 10- | 14. Race - Ame Black, Whit | |
| 50 | rs afte | by F | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced | 1√TYes 2□No If Yes, Give 142- Year or Dates: 42- | -46 | 1 ☐ Yes 2 ☐ No | Specify: | | | Specify: W] | hite |
| 2-003p | be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or itams 23e or 28e-f show event, the Medical Exercil ett. sist be nutified at event, the Medical Exercil ett. | | 15. Decedent's Ed | ucation | 16a Dece | dent's Usual Occupa | ation | | 16b. Ki | nd of Business | /Industry |
| מ | thin 7: 8. 8n "n | Completed | (Specify only highest grad | College (1-4or 5+) | | kind of work done of DO NOT use retired | | | _ | D C | |
| 7 | ed wii | Cou | 12 | | рераг | t. of Nat | | | 1 | | rcement |
| yland | ed is a second | Be | 17. Father's Name (First, Middle, Last) Alpha Marine | | | | | Name (First, Midda a Plight | | Sumame) | |
| | s 1 and 2 should be I Health and Mental tam 27 is marked other traumatic ev | ပ္ | 19a. Informant's Name/Relationship (7 | vne Print) | 19b Mailii | ng Address (Street a | | | | r Town State | Zin Code) |
| Z | | | Thelma L. Mari | | | Clover | | | • | | |
| ō, | es 1 and of Health f Itam 27 r other t | | 20a. Method of Disposition | 20b. P | | sition (Name of natory or other place | | Date | | cation - City or | |
| Ê | | | Magarial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify | | | | | 1/17/05 | East | New | Market,MD |
| Baltimore, | permit. Pag Department important: any injury o | | 21. Signature of Funeral Service Licent | | 22 | 2. Name and Addres | s of Facility | Frampto | m Fu | nera1 | Home, P.A. MD 21632 |
| Г | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | lications that caused the death | | | | | | ~ ~ ~ ~ , | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Myemia | 1 | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequence | | | | | | | |
| | · | _ | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a consequence) | | ne | | | | | months |
| | ted | nine | Cause (Disease or injury | . / | | n | | | | | GERTS |
| , | be executed ician and burial-transit | Examiner | that initiated events resulting in death) Last | c. Hu Panta Due to (or as a consequence | | | | | | | 1 |
| /60 | ate be executed hysician and the burial-transit | icai | (| d Atheros | cleno; | :15 | | | | | years |
| R 9 | rtifica ng ph | | IF FEMALE: | | | | | | | | |
| ROX | The law requires that the death certificate tte has been signed by the attending physbage 2 should be detached for use as the | Physician/Med | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta | Ideath 3 | Ectopic pregnancy | | | 2 | 23d. Date of de | livery Day Year |
| o. | at the dea by the a stached for | ysic | 1 Yes 2 No | 4□Pregnant at time of d 9□ Unknown | eath 5 | Other (specify) | | | | | , |
| 1 | es that thighed by be detact | | Part II. Dther significant conditions or | ontributing to death but not res | ulting in the u | nderlying cause give | en in Part I. | 23e. Di | tobacco u | se contribute to | o the cause of death? |
| ecords, | uires sign ld be | d by | | | | | | 10 | Yes 2 | □No 3□Pi | robably 4 Unknown |
| 000 | tw require s been si | Completed | | | | | | 24a. W | | 24b. Were at | utopsy findings available completion of cause of |
| Y | nysician: The law his certificate has I director, page 2 a | шо | | | | | | — au pe 1□ Yes | opsy formed? 2 1 No | death? | |
| ta | | BeC | 25. Was case referred to medical examiner? | | | | 26. Place of | Death (Check onl | | | |
| × > | Physic this ce al dire | Tof | 1 ☐ Yes 2 No | | ER/Outpatie | | 4 Nursi | ng Home 5 □ Re | | | city) |
| Division of Vital | ing F | ioo! | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | Work | ∤at k? Yes 2 ∐No | 28d. Describ | e how injur | y occurred | |
| 18 | Attandi death. ctor: A y the fi | icat | 2 Accident investigation 3 Suicide 6 Could not be | | ome farm st | | 165 2 110 | | (Street and | d Number or Ri | ural Route Number, |
| <u> </u> | i or A after Direction by | Certification; | 4 Homicide determined | building, etc. (Specif | y) | cot, ractory, critico | | | own, State, | | , |
| | To the Hospital or Attano within 24 hours after death To tha Funaral Director: completely filled in by the | Medical C | 29a. Certifier (Check only one) Certifying Ph. 2 Medical Exam | ysician: To the best of my kno niner: On the basis of examina and manner stated. | wledge, deat tion and/or in | h occurred at the tim vestigation, in my op | ne, date and p pinion, death | place, and due to the occurred at the time | e cause(s) e, date and | and manner as place, and due | s stated. e to the cause(s) |
| | To the | Me | 29b. Signature and title of certifier. | 201 | | 29c. License | | | | e signed (Mont | |
| | , , , , | |) SHR | Missey | | I | 759 | 35 | / | 11.15. | 05 |
| | | | 30. Name and address of person who a | 1000 010 | n 23a) (Type, | Print) fahman | s L.a. | ne, Ea | ston | , Mis | 05 21601 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | iture | | | | | | |
| | Regist | , - O | NOV 1 5 200 | 15 Beaus A | 4 Ago | arts) | | | | | |
| DH | MH 17 Rev 1/2 | 001 | | | Man . | | | | | | |

ORIGINAL

| | | | Please 1 | Type or Print in State of Maryla | | | | - | | _ | |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------|--------------------------------------|------------------------------------------|----------------------------|------------------------------------------------|---------------------------------------------|
| | | | 1 - For State Registrar | State of Maryta | | Certificate of | | i wentan m | ygierie Reg. No. | 11115 | 38123 |
| | | 44° | Decedent's Name (First, Middle, Last | ") | | 20.1.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 2000 | 2. Date of D | Death | | 3. Time of Death |
| | Physici /Medio | | Thomas Leste | r Matthews | , Jr | | | Month | Day | 2005 | 21:40 |
| | Examin | | 4a. Facility Name (If not institution, give | | | 4b. City, Town, o | | | | County of Death | |
| * | | | University OL/ | | | | Balt If Under 24 H | imore | | altimore. | |
| | Funeral Director | | 5. Social Security Number 6. Se 217-30-7572 Usual Residence of Decedent | TK | 7 1 Y | Months Days | Hours M | | 17,19 | 33 Mary | place (State or Foreign ntry) Land |
| | death with the Maryland me 23a or 28a-f show (must be notified at | ctor | 10a. State 10b. County MD Dorche | | | or Location r 1 o c k | | | | | 10d. Inside City Limits 1 ☐ Yes 2 🖔 No |
| | ath with the 23a or 28 | ral Director | 10e. Street and Number 4430 Elwood Ca | mp Road | | 10f. Zip Code 2 1 | 643 | | | zen of What Cou ced Sta | • |
| 36 | be filed within 72 hours after death with the Marylar lat Hygiene. d other than "natural", or Iteme 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 21□ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☒Yes 2 ☐ No If Yes, Give Year or Dates: 54- | | 13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No | an, Mexican, Pu | (Specify Yes or Nerto Rican, etc.) | 10- | 14. Race - Ameri Black, White Specify: B | |
| 5 | 2 hou | | 15. Decedent's Edu | ıcation | 16a. C | ecedent's Usual Occup | ation | | 16b. Ki | nd of Business/Ir | dustry |
| 215 | ithin 7 ne. nen "n | Completed | (Specify only highest grad | College (1-4or 5+) | | Give kind of work done ife. DO NOT use retired | | vorking | Stat | te Highw | ay |
| 121 | filed w Hygier other th | | 12 17. Father's Name (First, Middle, Last) | | під | hway Mainte | | lame (First, Midd | | inistrat | ion |
| au | | To Be | Thomas Lester | r Matthews. | Sr. | | | abeth V | | , | |
| Maryland 21215-0036 | s 1 and 2 should be f Health and Menta item 27 le marked other traumatic ev | | 19a. Informant's Name/Relationship (7) Ophelia F. Mat | ype, Print) | 19b. N | Mailing Address (Street | and Number or | Rural Route Num | ber, City o | r Town, State, Zij | 21643 |
| Ğ, | of Hea of Hea fitem | | 20a. Method of Disposition | 20b. | Place of E | Disposition (Name of crematory or other place | | Date | - | cation - City or T | |
| Ĕ | Pages ment of I ant: If it ury or o | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | | | n Shore Vet | . 11/ | 21/05 | | | laryland |
| Baltimore, | permit. Pages Department of Important: If i eny injury or once. | | 21. Signature of Funeral Service Licens | 99 | | 22. Name and Addre | ss of Facility F ain St | rampton ., Fede | n Fur erals | neral H sburg, | ome, P.A. MD 21632 |
| 12 J | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | lications that caused the deane cause on each line. | ath. Do no | t enter the mode of dyin | g, such as card | iac or respiratory | arrest, | | Approximate Interval Between |
| 養 | Pnysician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | a. Myoca Due to (or as a conse | | u infar | chor | | | | Onset and Death |
| 他 | | lner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a conse | equence of |): | | | | | |
| ,60, | be executed sician and burial-transit | al Examiner | that initiated events resulting in death) Last | Due to (or as a conse | equence of |): | | | | | |
| 9/89 | ificate g physas the | edlo | | d | | | | | | | |
| O. Box | ne death certificate be the attending physicia thed for use as the bur | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown | tal death | 3 Ectopic pregnancy 5 Other (specify) | | | 2 | 23d. Date of delive Month | ery Day Year |
| <u>.</u> | law requires that the de as been signed by the a .2 should be detached t | þ | Part II. Other significant conditions co | ntributing to death but not re | sulting in t | he underlying cause giv | en in Part I. | | | | ne cause of death? |
| Hecords, | o - 0 | Completed | | | | | | 24a. Wa auto | s an opsy formed2 | 24b. Were auto | psy findings available mpletion of cause of |
| Vital | ician: The certificete rector, pag | a) | 25. Was case referred to medical | | | | 26 Place of D | 1 ☐ Yes eath (Check only | 2 No | 1 Tes | 2 No |
| | Physician: r this certifice ral director, p | To B | examiner? | Hospital: 1 Inpatient 2 | ☐ ER/Outp | atient 3 DOA Oth | 00 | Home 5 Res | | Other (Specif | v) |
| ion of | fune | | 27. Manner of Death 1 Manual 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Tin Inju | ne of 28c. Injury | | 28d. Describe | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| DIVISION | tel or Atters after de el Directo | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At building, etc. (Spec | home, farm | n, street, factory, office | | 28f. Location City or To | (Street and own, State) | d Number or Rura | d Route Number, |
| | To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the | Medical | 29a. Certifier 1 Certifying Phy cone) 1 Medical Exami | sician: To the best of my kr ner: On the basis of examin and manner stated. | nowledge, on and/ | death occurred at the tin or investigation, in my o | ne, date and pla pinion, death oc | ce, and due to the curred at the time | e cause(s) , date and | and manner as s place, and due to | ated. o the cause(s) |
| | To the within 2 To the complet | | 29b. Signature and title of certifier 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | nh | | 29c. Licens | | | | e signed (Month, $13,2$ | Day, Year) |
| | | | 30. Name and address of person who of Ellen Lemks | empleted cause of death (Ite | om 23a) (Ty | ne St. (| Baltin | ise r | W (| 21201 | |

State Registrar 31. Date filed (Month, Day, Year)
NOV 1 5 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 20 0 5

| | | | For State Registrar | State of Mai | ryland | | irtment of H tificate of I | | | giene Reg. No. | 005 | 38124 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------|-----------------------------------|------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------|------------------------|-----------------------------------------|--------------------------------------------------------------|
| | Physici /Medic | an | 1. Decedent's Name (First, Middle, Las | 3 No | RIS | seN | | | 2. Date of De. Month | | Year | 3. Time of Death |
| 1.00 | Examin | | 4a, Facility Name (If not institution, give | street and number) | The | = LAK | 4b. City, Town, or | Location of Death | ey | 4c. | County of Dea | ornico) |
| | Funeral Director | - 36 | 5. Social Security Number 212–30–5103 | | (In yrs. ia | st birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs | 8. Date of Bird (Month, Da Aug. 11 | th y, Υθας) , 19 | 9. Bi | rthplace (State or Foreign ountry) ryland |
| | ryland how Lat | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Loc | cation | | | | | 10d. Inside City Limits |
| | the Ma 28a-f s | Director | MD Wicomi | .co | De | 1mar | 10f. Zip Code | | | 10a Citia | zen of What C | 1 ☐ Yes 2 🛣 No |
| | th with 23a or | | 26344 Delmar Road | l | | | 21875 | | | | S.A. | ountry |
| Maryland 21215-0036 | hours atter death with the Maryland turst', or items 23a or 28a-f show at Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: |) | lf 1 | Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No | ispanic Origin? (Sp in, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | | I4. Race - Am Black, Whi Specify: | |
| 15-0 | CV 65 UII | Completed | 15. Decedent's Ed (Specify only highest grad | ucation de completed) | | (Give I | ent's Usual Occupa kind of work done of OO NOT use retired | during most of work | ing | 16b. Kir | nd of Business | /Industry |
| 212 | d within 7. giene. ir than "n | omo | Elementary/Secondary (0-12) | College (1-4or 5+ 4 | | | | Presiden | nt | Ins | surance | Company |
| pu | ild be tiled tental Hygie ked other ilc event, te | Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Name | | Maiden | Sumame) | |
| ryla | should ind Men i marke umatic | 2 | Patrick Allison M 19a. Informant's Name/Relationship (7) | | | 19h Mailin | a Address /Street | Polly Ma and Number or Rur | | er City or | Town State | Zin Codel |
| | 12 1 10 1 10 1 10 | | Samuel Ridgely Mo | | n) | | 0 Delmar | | Delmar, | | 21875 | 2.tp C004) |
| Baltimore, | of H | | 20a. Method of Disposition 1 Burial 2 | Removal from State | Crei | ace of Dispos | sition (Name of natory or other place OT | ee) | Date 13, 200 | 20c. Lo | cation - City o | Town, State Delaware |
| Balti | permit. Page Depertment Important: If any injury or once. | | 21. Signature of Funeral Service Licen | 500 | DCI | Sh. | Name and Address nort Fune B E. Grov | ss of Facility | | | 9940 | Dezaware |
| | Physician /Medical Examiner | ner | 23a. Part1. Enter me disease, or count shock, or heart failure. List only of list on the disease or condition resulting in death) Sequentially list or dillione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | one cause on each line | consequi | Do not enter NT/ ence of): T/o~ | er the mode of dyin | g, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| 68760, | The taw requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit | edical Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | consequ | ence of): | | | | | | |
| P.O. Box (| at the death certific by the ettending parached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown | Fetal | death 3 | Ectopic pregnancy Other (specify) | | | 2 | 3d. Date of de Month | blivery Day Year |
| | w requires that been signed be should be deta | by | Part II. Other significant conditions of | ontributing to death but | not resu | Iting in the un | nderlying cause give | en in Part I. | 23e. Did t | | A ^v | o the cause of death? robably 4 \(\subseteq Unknown |
| Vital Records, | | Completed | | | | | | | 24a. Was autor perfo 1 \(\text{Yes} \) | | 24b. Were a prior to death? | utopsy findings available completion of cause of s 2 6 |
| Z | ysicien: s certific director, | o Be | 25. Was case referred to medical examiner? 1 Yes 20 No | Hospital: 1 ☐ Inpatien | , 205 | ER/Outpatient | t 3 DOA Oth | 26. Place of Deat er: 4 ☐ Nursing Ho | | | Yours (C- | 11000105 |
| ion of | ding Ph | - | 27. Manaer of Death 1 SNatural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day | | 28b. Time of Injury | 28c. injur | y at | 28d. Describe | | | acity) HOSPICE |
| Division | tat or Atters after de el Directo ed in by the | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28f. Location (3 City or Tox | | | tural Route Number, | | | | | |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the | Medical | (Check only /2 Medical Examone) | ysician: To the best of liner: On the basis of a and manner state | examinati | vledge, death ion and/or inv | occurred at the tin restigation, in my o | ne, date and place, pinion, death occur | and due to the red at the time, | cause(s) date and | and manner a place, and du | s stated. e to the cause(s) |
| | T With Common | Σ | 29b. Signature and title of certifier | - 2 | rn | D | 29c. Licens | | | | - | th, Day, Year) |
| | 1. Ca | | 30. Name and address of person who de CHUAM UAS | is 262 | 66 | 23a) (Type, I | Print) DWWDDD | ct. 8 | ALISBU | RY | us | 21801 |
| | Sta Regist | rar | 31. Date filed (Month, Day, Year) NOV 1 4 2 | 32. Pogistrar | s signat | y. Ag | rave | | | | | 7.7. |
| 마 | -IMH 17 Rev 1/2 | 001 | | | | 12 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. No. UU5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROSE ELLA MONAHAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 4 1915 5. Social Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1□M 2ĂF Months Yrs MARŸĽÄND 90 Director 214 07 6404 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 27 le marked other than "natural", or items 23s or 28s-f ehow traumstic event, the Madical Examinar must be notified at 1 □Yes XXNo Directo MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. snt: If item 27 Ie marked other then "natural", or Items 23s or? 19104 NATIONAL HIGHWAY, NW 21532 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NANCY SHAW HARRY MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DEREK MONAHAN / SON 10610 COOL SPRING LANE, FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once. N Burial 2 ☐ Cremation 3 ☐ Removal from State ST. MICHAEL'S CEMETERY 11/19/05 FROSTBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 60 W. MAIN STREET 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acent preum mi A 3 Rays disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit Due to (or as a consequence of) Box 68760, the attending physician Hospital or Attending Physician:> The law requires that the death certificate be Physician/Medicai the use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day jo Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown 9 Unknown ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2000 1 Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred After t Certification: 5 Pending ↑ ☑Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide If criifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 8 2005

Route 36

| | 1 | For Amend Item State of Management Amend Item 3 per Dr. | aryland / Depa , G849 , IL/2 / | utment of H 8/05dhb tificate of I | ealth and Mo Death | ental Hyg | iene 005 | 38126 |
|-------------------|---------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------|-----------------------------------------------------------|---------------------------------|----------------------------------------------|------------------------------------------------|
| ** 4. | ш | Decedent's Name (First, Middle, Last) | | | | 2. Date of Deat Month | h Day Year | 3. Time of Death |
| Physici Medio/ | _ | Helane E. Myers | | | | | er 8,200 | |
| xamin | | a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | Location of Death | | 4c. County of Dea | |
| ·*)- | | 8012 Goldcup Lane | e (In yrs. last birthday). | Bowi If Under 1 Year | e If Under 24 Hrs. | 8. Date of Birth | Maryla | and |
| ral | | 1 ☐ M 2 t ☐ F | 47 Yrs. | Months Days | Hours Min. | Month, Day, June 2: | | rthplace (State or Foreign ountry) Washington, |
| | 1 | 578-86-9420 Usual Residence of Decedent | | | | June 2 | 3,1936 | 10d. Inside City Limits |
| | | 10a. State 10b. County | 10c. City, Town or Lo | cation | | | | 10d. Inside City Limits 1 ☐Yes 2☐No |
| | ctor | MD Prince Georg | es Bow | | | | | |
| | Dire | 10e. Street and Number | | 10f. Zip Code | | 1 | 0g. Citizen of What C | ountry? |
| - | ra | 8012 Goldcup Lane | Ever in IIS 13 1 | 2071 | | crfv Yes or No- | United S | |
| | by Funeral Director | 11. Marital Status 1 Never Married | A1- | f Yes, specify Cuba 1 ☐ Yes 2 HO | ispanic Origin? (Spe an, Mexican, Puerto I Specify: | Rican, etc.) | Black, Whi Specify: B | ite, etc. lack |
| | ted | 15. Decedent's Education | 16a. Deced | dent's Usual Occup | ation during most of workii | na | 16b. Kind of Business | |
| | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or | life. I | DO NOT use retired | d) | | | & Trademar |
| | S | | ears | Patier | t Examii | | | Government_ |
| | Be | 17. Father's Name (First, Middle, Last) | | | | | | |
| | ဥ | Lloyd Morell 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailir | ng Address (Street | Helen I and Number or Rura | | r, City or Town, State, | Zip Code) |
| | | Robert M. Myers / Hush | | | | | MD 2071 | |
| | | 20a. Method of Disposition | 20b. Place of Dispo | osition (Name of | ce) | ate | 20c. Location - City o | |
| | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Harmony | Memori | al Cem. | 11/16 | /05 Land | dover,MD |
| ė | 1 | 21. Signature of Funeral Service Licensee | | 2. Name and Addre | | | 1 11 | |
| once. | | 1-0-C | 1 2 | Austin 1 | loyster 1 | runera W-Weeh | ington 1 | nc 20011 |
| | | 23a. Part1. Epter the disease of combications that cause shock of heart failurer. List only one cause on each | d the death. Do not en | ter the mode of dyli | ng, such as cardiac d | or respiratory ar | rest, 5 0011, | Approximate Interval Between Onset and Death |
| n | | disease or condition | Stage Mul | tiple So | clerosis | | | years |
| al er | | regulting in death) | s a consequence of): | | | | | |
| | l _{en} | Sequentially list conditions, b. Due to (or a | s a consequence of): | | | | | |
| | ntne | cause. Enter Underlying Cause (Disease or injury | . | | | | | |
| | Examiner | that initiated events | s a consequence of): | | | | | |
| | | d | | | | | | |
| | ledi | IE FEMALE. | | | | | | 1 |
| | Physician/Medical | | 2 Fetal death 3 | Ectopic pregnanc | у | | 23d. Date of d Month | lelivery Day Year |
| | Sici | 1 ☐ Past 12 months? 1 ☐ Yes 2 ☐ 10 9 ☐ Unknown 9 ☐ Unknown | at time of death 5 | Other (specify) | | | | |
| | Phy | Part II. Other significant conditions contributing to death | but not resulting in the u | underlying cause or | ven in Part I. | 23e. Did to | bacco use contribute | to the cause of death? |
| | d by | | • | • | | 1 🗆 1 | /es 2 No 3 □ | Probably 4 Unknown |
| | Completed | | | <u> </u> | | 24a. Was | | autopsy findings available |
| | E G | | | | | autop perfo | rmed? prior to death | o completion of cause of |
| | e Co | 25. Was case referred to medical | | - | 26. Place of Deat | 1 Yes | Α | es 2 No |
| | 0 | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa | tient 2 ER/Outpatie | ent 3 DOA Ot | hor | - | dence 6 Other (Sp | pecify) |
| | n: To | 27. Manner of Death 28a. Date of In | | | | A | now injury occurred | |
| | atio | 2 Accident investigation | injury injury | | Yes 2 No | | | |
| | tiffica | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of 1 building, | njury - At home, farm, s | treet, factory, office | | 28f. Location (S City or Tox | Street and Number or vn, State) | Rural Route Number, |
| | Certification: | | | | | | | |
| | edical | 29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis and manner | of examination and/or i | th occurred at the t nvestigation, in my | ime, date and place, opinion, death occur | and due to the red at the time, | cause(s) and manner date and place, and d | as stated. fue to the cause(s) |
| | Med | 29b. Signature and title of certifier | | 29c. Licen | se number | | 29d. Date signed (Mo | onth, Dey, Year) |
| | | | | D | L9431 | | 11/16/ | 05 |
| | | 30. Name and address of person who completed cause o | f death (Item 23a) (Type | | | | | |
| | | Dr Frank Ryan 117 | 01 Living | ston Ro | ad Suite | #103 | Ft. Wash | ington, MD |
| s | tate | 31. Date filed (Month, Day, Year) 32. Regi | strar's Signature | 2 8 | | | | 20744 |
| | trar | NOV 2 8 2005 | A GORAGE | | | | | |

DHMH 17 Rev 1/2001

Registrar

the Maryland

filed within 72 hours after

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) P_M Physician NOV 10 2005 4:07 RAYMOND MELVIN OVERGAARD /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 X M 2 □ F OCT.20,1943 NEW JERSEY Director 144-34-2309 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No MARYLAND CHARLES WALDORF Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with U.S.A. 20603 2728 VISTA COURT death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? XXXes 2 □ No If Yes, Give] 969-19 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE -1990 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. NAVY College (1-4or 5+) Elementary/Secondary (0-12) U.S. GOVERNMENT 12 COMMANDER permit. Pages 1 and 2 should be filed ' Department of Health and Mental Hygie Important: If Itam 27 is marked othar I any injury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HANS MELVIN OVERGAARD KAMILLA LEGAARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2728 VISTA COURT, WALDORF, MD 20603 ELAINE OVERGAARD-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ Removal from State METROPOLITIAN CREMATORY 11-15-05 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee MO0479 2. Name and Address of Facility DUC RAYMOND FUNERAL SERVICE, r LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NON SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit and Due to (or as a consequence of): physicien IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 1 Yes 2 No 3□ DOA ို this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, Hospital or Attending Physician: Director: A hours after Fo the .
within 24 hours.
the Funaral C

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifiei

(Check only one)

29b. Signature and title

address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an LCDR MC JOEL NATIONS 31. Date filed (Month, D istrar's Signature

14 pm st 0101231164 (VA) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

| | , | 1 - State Registrar | ate of Mar | | artment of H | | d Mental Hygi | ene g. No. 005 | 38129 | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------|--|--|
| Physic /Medi | | Decedent's Name (First, Middle, Last) LILLIAN HELEN PR | EVRATI | L | | | 2. Date of Death Month NOVEMBER | | 3. Time of Death 7:00 AM | | |
| Exami | ner | 4a. Facility Name (If not institution, give street 2424 COON CLUB ROAD | | | 4b. City, Town, or WESTMIN | ISTER | | 4c. County of Death CARROLL | | | |
| Funeral Director | | 5. Social Security Number 215-09-8378 Usual Residence of Decedent | | In yrs. last birthday) 3 Yrs. | If Under 1 Year Months Days | If Under 24 I Hours & | Hrs. 8. Date of Birth Min. SEPTEMBE | ^{Уеаг)} 18 , 1912 | rthplace (State or Foreign Ountry) MARYLAND | | |
| Maryland f show | or | 10a. State 10b. County MARYLAND CARROLL | 1 | Oc. City, Town or Lo | | | | | 10d. Inside City Limits 1 ☐ Yes 2 💢 🖔 0 | | |
| with the ! ta or 28a- | Direct | 10e. Street and Number 2424 COON CLUB ROAD | | | 10f. Zip Code 21157 | 7 | | g. Citizen of What C | ountry? | | |
| 170000 172 hours after death with the Marylan "naturel", or Items 23a or 28a-f show odical Examirer must be notified at | by Funeral Director | 1 Never Married 2 Married 1 € | as Decedent Evened Forces? Yes XXNo Yes, Give par or Dates: | 1 | Vas Decedent of His f Yes, specify Cubar I □ Yes 2∰Xo | spanic Origin? n, Mexican, Pi Specify: | ? (Specify Yes or No- uerto Rican, etc.) | 14. Race - Am Black, Whi | te, etc. | | |
| ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 ie marked other then "naturel", or Items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at | Completed | 15. Decedent's Education (Specify only highest grade com | | (Give | lent's Usual Occupa kind of work done d OO NOT use retired) DICAL SEC | uring most of | working | 6b. Kind of Business | | | |
| an yiailo 4.14. 2 should be filed within and Mental Hygiene. ie marked other then reumatic event, ILE Market | To Be C | 17. Father's Name (First, Middle, Last) JOSEPH KALIVODA | | | | | Name (First, Middle, M | laiden Sumame) | | | |
| stand 2 should lost the stand and Men of Health and Men item 27 is marker other treumatic. | | 19a. Informant's Name/Relationship (Type, Pr CHRISTINA GORSKI/DAUC | GHTER | 2424 | COON CLUE | | Rural Route Number, WESTMINST | | <i>Zip Code)</i> I 157 | | |
| parmit. Pages 1 Department of He Importent: If iter any injury or oth | | 20a. Method of Disposition 1 1 4 □ Donation 5 □ Other (Specify) | I | 20b. Place of Dispo- cemetery, cren LAKEVIEW | natory or other place | " 11 | | 0c. Location - City or SYKESVILLE | Town, State E, MARYLAND | | |
| permit. Page Department of Importent: If any injury or once. | | 21. Signature of Funeral Service Licensee | Paylor | MY 91 | WILLIS S | RAW FU | | PER, MD | 21157 | | |
| Physician | | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one caul Immediate Cause (Final disease or condition resulting in death) | se on each line. | | | | diac or respiratory arresponds $D : A \rightarrow A \rightarrow A$ | st, | Approximate Interval Between Onset and Death | | |
| rate be executed by sician and the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit | dical Examiner | Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseas or if jury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| The law requires that the death certificate are been signed by the attending physpage 2 should be detached for use as the | hysiclan/Medic | in the past 12 months? | yes, outcome of Live birth 2 [Pregnant at tim | Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of de Month | livery Day Year | | |
| quires that | ed by P | Part II. Other significant conditions contribut | ing to death but r | not resulting in the ur | nderlying cause give | n in Part I. | | _ | o the cause of death? | | |
| The law requir | Completed | | | | | | 24a. Was an autopsy perform | prior to | utopsy findings available completion of cause of | | |
| Physicien: The this certificate al director, pag | To Be | 25. Was case referred to medical examiner? 1 Yes 2 Hospita | al: 1 Inpatient | 2□ER/Outpatien | Other | | Death (Check only one g Home 5 Aesider | | cify) | | |
| ng I ifter | ertification: | 1 Actural 5 Pending 2 Accident investigation | a. Date of Injury (Month, Day Y | | | at ? es 2 □ No | 28d. Describe hov | vinjury occurred | | | |
| Itel or Attending after death. rel Director: After death. | O | 4 Homicide determined 286 | building, etc. (| | | | City or Town, | | | | |
| To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in | ledical | | To the best of r in the basis of ex and manner stated | kamination and/or inv | occurred at the time restigation, in my op | e, date and pl inion, death o | ace, and due to the cat ccurred at the time, dat | use(s) and manner as e and place, and due | s stated. e to the cause(s) | | |
| 2 M 2 M | Z | 29b. Signature and title of certifier Remode F. | m. | MM | 29c. License | number | 1 | d. Date signed (Mont | th, Day, Year) | | |
| 3 | | 30. Name and address of person who complet ROBERT L. MOSS, 11 | | | | REISTEF | RSTOWN, MD | 21136 | 1 | | |
| St Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 0 7 2005 | 32. Registrar's | | Soul . | | | | | | |

| | | | Please | Type or Prin | | | | nk. Ensure | • | | _ | |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------|---------------------|-----------------------------------|----------------------------------------------------------|-------------------|------------------------------|----------------------------|------------------------------------|
| | | P | For Stete | State of Mi | arylari | _ | rtificate (| | i Mentai n | | 71115 | 38130 |
| | | | Registrar 1. Decedent's Name (First, Middle, La | st) | | | rimeate | Dealit | 2. Date of I | Rag. No | . • • • | 3. Time of Death |
| | Physici | | Hewitt R. Pinder | | | | | | Month | but. Da | y Year 200 | 1/61/7 14 |
| | /Medic Examin | | 4a. Facility Name (If not institution, giv | | -// | | | m, or Location of Di | | | County of Dea | ath , |
| | Funeral | | 5. Social Security Number 6. 5 | Sex 7. Ag | | last birthday, | If Under 1 Y | | irs. 8. Date of I | Birth | | rthplace (State or Foreign ountry) |
| | Director | | 218-30-2108 Usual Residence of Decedent | I ⊠ M 2□F | 70 | Yrs. | Months Da | ays Hours N | April | Day, Year 28 1 | 935 De | laware |
| | yland how | | 10a. State 10b. County | | | y, Town or L | | | | | | 10d. Inside City Limits |
| | Ba-1 s | ctor | Maryland Queen Ar | nne's | Que | en An | ne | | | | | 1X Yes 2 □ No |
| | vith th | Dire | 10e. Street and Number | | | | 10f. Zip Co | | | 10g. C | itizen of What C | ountry? |
| | s 23a | eral | 13609 First Stree | 12. Was Decedent | Ever in II | S 12 | 216 | | (Specify Ves or | No | USA 14. Race - Am | erican Indian |
| 920 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumette event, it a Modical Exattion chart has collised at ODGE. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | Armed Forces? 1 Tes 2 X If Yes, Give Year or Dates: | , | 3. 13. | If Yes, specify 1 ☐ Yes 2 🔯 | of Hispanic Origin? Cuban, Mexican, Pu No Specify: | ento Rican, etc.) | NO- | Black, Whi | |
| 15-0 | n 72 ho n matur | Completed | 15. Decedent's E (Specify only highest gr | ade completed) | | (Give | edent's Usual O | one during most of | working | 16b. F | Kind of Business | s/Industry |
| 212 | d withing iene. | mo | Elementary/Secondary (0-12) | College (1-4or | 5+) | car | penter/ | truck dr | iver | 1 | umber c | ompany |
| br | e filed al Hyg othe vent, | BeC | 17. Father's Name (First, Middle, Last |) | | | | 18. Mother's | Name (First, Midd | lle, Maide | n Sumame) | |
| ylar | Ments Ments arked | To E | John D. Pinder | | | | | Pearl | Dill Pi | nder | | |
| lan | 2 sho and Is mu | | 19a. Informant's Name/Relationship | Type, Print) | | | | reet and Number of | | | | Zip Code) |
| ره د | l and lealth im 27 her ti | | John Pinder/ son | | 20h P | | Box 84 sosition (Name of | Greensbor | o, Maryl | | 21639 .ocation - City o | r Town State |
| Baltimore, Maryland 21215-0036 | Pages 1 sent of H int: If ite | | 20a. Method of Disposition 1 | | 0 | emetery, cre | matory or other | place) | | | | , Maryland |
| Balti | permit. Departn Importa any inju | | 21. Signature of Funeral Service Lice | nsee | | F. | leegle . | and Helfe | nbein Fu | mera | 1 Home, | P.A. |
| | *1 | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | pplications that cause | d the death | | | 60 Greens dying, such as car | | | 39 | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | | G / | F. G | 105: 5 | | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as | a consequ | uence of): | 110 | V (121) | | | | |
| | Examiner | 1 | Sequentially list conditions, | b. Cov | · Pc | Im | coal | vosi s | | | | |
| | sit s | lne | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequ | uenca of). | | | | | | |
| | executed in and ial-transi | Examiner | that initiated events resulting in death) Last | c Due to (or as | a consequ | uence of): | | | | | _ | |
| 092 | 9 5 5 | | | d | | , | | | | | | 1 |
| 687 | ificate g phy as the | edic | | | | | | | | | | |
|). Box 68760, | Attending Physicien: The law requires that the death certificate be refeath. setor: After this certificate has been signed by the attending physicity the funeral director, page 2 should be detached for use as the but | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 ☐ Fetal | I death 3 | ⊒Ectopic pregn ⊒ Other (specif | | | - | 23d. Date of de Month | Day Year |
| P.O. | that the de ed by the detached | Phy | Part II. Other significant conditions | contributing to death t | out not resi | ulting in the | undertving caus | e given in Part I. | 23e. Di | d tobacco | use contribute t | to the cause of death? |
| ds, | uires tha signed d be def | d by | | | | | | | 1 (| ∃Yes 2 | !□No 3□P | robably 40thknown |
| COL | aw requir is been si 2 should | ete | | | | | | | 24a. W | | 24b. Were a | utopsy findings available |
| Re | The lav | Completed | | | | | | | pe | topsy rformed? ≥ 20 No | death? | completion of cause of |
| ta | sicien: Th certificate rector, pag | Be C | 25. Was case referred to medical | | | | | 26. Place of | Death (Check onl | | 5 | |
| ξ | Physici this cer al direc | To B | examiner? 1 ☐ Yes 2 No | Hospital: 1 Inpati | ent 2 | ER/Outpatie | nt 3 DOA | Other: 4 - Nursin | g Home 5 ☐ Re | sidence | 6 □Other (Spe | ecify) |
| 0 U | Jing Ph J. After th funeral | | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | ury ay Year) | 28b. Time of Injury | of 28c. | Injury at Work? | 28d. Describ | | | |
| Sio | ttendii death. stor: A rthe fu | catl | 2 Accident investigation 3 Suicide 6 Could not I | 20 | | | | 1 ☐ Yes 2 ☐ No | 204 1 | /04 | - 111 | |
| Division of Vital Records, | el or At s after d al Direct ad in by | Certification: | 4 Homicide determined | 289. Place of in | ijury - At ho tc. <i>(Specif</i>) | ome, farm, si | treet, factory, of | fice | | own, Stat | | Rural Route Number, |
| | To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page | edical (| | hysician: To the best miner: On the basis of and manner si | of examina | | | | | | | |
| | Fo the vithin Fo the comple | Me | 29b. Signature and title of certifier | | | | 29c. Li | cense number | | 29d. Da | ate signed (Mon | th, Day, Year) |
| | ->-0 | | Don m | of no | 10- | lan | 00 | 00531 | 10 | Nov | omber | 10.2005 |
| | | | 30. Name and address of person who | | | | , Print) | | + | | | ; /- |
| | | | Dr. Dennis DeShie | | | | gton St | reet East | on, MD 2 | 1601 | | |
| | | ate | 31. Date filed (Month, Day, Year) | 32. Regist | rar's Signa | ture | 100 a | | | | | |
| | Regist | rar | MEEV 1 4 700° | J. Santan | 11 11 | 4400 | ASI. | | | | | |

Hwith ANDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day MILDRED PAVONE Month **Physician** 5:39 AM VIRGINIA NOVEMBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Çity, Town, or Location of Death 4c. County of Death Examiner ohns MORE 405 FIT. Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Davs Hours 1 □ M 2 □ N 1171271927 Delaware 222-12-9277 77 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Experience must be notified at 10a. State TY Yes 2 No Virginia Accomac Horntown Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23395 Pintail Drive USA Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ont of Health and Mental Hit: If item 27 is marked outly or other treumatic even Be Virginia Brittingham William Kettner 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Pavone/husband PO Box 632, Horntown, VA 23395 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages permit. Page Department o Important: If i any injury or once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory 11/5/05 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dovid H. CFSP mono 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRA-ABDOMINAL BLEED 12 HOURS /Medical Examiner MESENTERIC INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed SUB ARACHNOID HEMORRHAGE burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year 4□Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has certificate 1 Yes 2X No 25. Was case referred to medical examiner?
1 ★ Yes 2 ☐ No director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 XNatural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: filled in by the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide within 24 hours after the Hospitel the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 RES-000 NOVEMBER 4, 2005 M.D.

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 0

8 2005

MICHAEL AWAD, 600 NORTH WOLFE STREET, BACTIMORE, MARYLAND 21287-9106

CHESTER L. PERDUE

| Division of Vital Records, P.O. Box 68760, | the Hospitel or Attending Phyelcien: The law requires that the death certificate be executed in 24 hours after death. The Funerel Director: After this certificate has been signed by the attending physician and pietely filled in by the funeral director, page 2 should be detached for use as the burial-transit |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ō | shy this |
| Division | the Hospitel or Attending I in 24 hours after death. The Funerel Director: After pletely filled in by the funer |

| | | 1 - For State Registrar | State of Maryland | | rtment of H | | | piene 05 | 38132 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------|-------------------------------------------|--------------------------------------------|-------------------------------------|--------------------------------------------|---------------------------------------------------------|
| Disconici | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea Month | th | 3. Time of Death |
| Physicia /Medic | | Chester Lafa | yette Per | cdue | | | Nov. 8 | Day Ye. 2005 | 7:30 P M |
| Examin | er | 4a. Facility Name (If not institution, give s | treet and number) | | 4b. City, Town, or | Location of Death | ı | 4c. County of D | eath |
| | | SALISBURY REHAB & | | | SALISBUI | RY, MD. 2 | 21804 | WICOM | ICO |
| Funeral Director | | 5. Social Security Number 6. Sex 216–14–9540 | M 2□F 7. Age (In yrs. la 85 | st birthday) | Months Days | If Under 24 Hrs. Hours Min. | (Month, Day | | Birthplace (State or Foreign Country) |
| | | Usual Residence of Decedent | 0.5 | | | | 4/16/1 | 920 M | Maryland |
| yland yland | | 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 10d. Inside City Limits |
| Marfal | tor | Maryland Wicomic | o De | elmar | | | | | 1 ☐ Yes X☐ No |
| or 28 | Olre | 10e. Street and Number | | | 10f. Zip Code | | 1 | 10g. Citizen of What | Country? |
| ath w | ral | Bi-State Blvd. | | | 218 | | | USA | |
| er de | Funeral Director | | Was Decedent Ever in U.S Armed Forces? | . 13. V | Vas Decedent of Hi Yes, specify Cuba | ispanic Origin? (Sp n, Mexican, Puerto | pecify Yes or No- p Rican, etc.) | 14. Race - A Black, W | American Indian, Vhite, etc. |
| Ir. or | by F | 1 Never Married 2 Married 3 Widowed 4 Vivorced | 1 Tyes 2 X No If Yes, Give Year or Dates: | 1 | ☐Yes 2X No | Specify: | | Specify: W | hite |
| 2 hou | ted | 15. Decedent's Educ | eation | 16a. Deced | ent's Usual Occupa | ation | | 16b. Kind of Busine | ess/Industry |
| thin 7 | ple | (Specify only highest grade | Completed) College (1-4or 5+) | (Give i life. [| kind of work done o OO NOT use retired | luring most of worl) | king | | · |
| ed wil | Completed | 12 | _ | Thurm | adot Opei | rator | | E.I. DuPo | ont Co. |
| be (illed H) | Be | 17. Father's Name (First, Middle, Last) | _ | | | | | Maiden Sumame) | |
| i Men I Men Parke | ို | J. Lafayette Perdu | | | | | ce Jones | | |
| 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 Is marked other than "naturel", or tems 23a or 28a-f show ther traumatic event, the Modical Exactinational be natified at | | 19a. Informant's Name/Relationship (Type Rita Perdue—Dayto | | | g Address <i>(Str</i> eet a Livers End | | | r, City or Town, Stat | e, Zip Code) |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinating must be notified at 9088. | | 20a. Method of Disposition | not Di- | | | | | 20c. Location - City | or Town State |
| Pages nent of 8 int; If it | | 1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify) | emoval from State Jeru | metery, crem .salem | natory or other plac U.M. Chu | rch | 2/05 | Parsonsbu | |
| nit. P artme orten Injur | | 21. Sunature of Funeral Service License | | merer, | / | | | | |
| permit. Departr Importe any Inju | | Ju Hoos | nu - | - J. 100 | 501 Snow | Hill Rd. | , Salisb | otessional oury, MD 2 | Association |
| | | a. Part1. Enter the disease, or complice shock, or heart failure. List only on | cations that aused the death. | | | | | | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition | Ca a said | 1 | 6.6 | 1/12 | 2 | dino | Onset and Death |
| /Medical | | resulting in death) | Due to (or as a conseque | ence of): | nan v | 0 000 | and y | o Copies | geors |
| Examiner | | Sequentially list conditions, b | 02/22/ | un | Thay. | 8/1 | actoria | | year |
| ed isit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o) as a conseque | ence of): | | | | | |
| xecut and al-trar | xan | that initiated events cresulting in death) Last | Due to (or as a conseque | ence of): | | | | | - |
| cate be executed chysician and the burial-transit | dical E | 4 | | | | | | | |
| g phy as the | 0 | | | | | | - | | |
| leath certific attending p I for use as | Physician/M | IF FEMALE: 23b. Was decedent pregnant 23 | 3c. If yes, outcome of pregnand 1☐Live birth 2☐Fetal of | | Ectopic pregnancy | | | 23d. Date of | delivery |
| deat | sicia | in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \) | 4 Pregnant at time of dea | | Other (specify) | | | Month | Day Year |
| that the de ned by the a detached t | hy | 9 Unknown | | | | | | | |
| w requires that been signed I should be det | by | Part II. Other significant conditions con | tributing to death but not result | ting in the ur | iderlying cause give | en in Part I. | | | e to the cause of death? |
| requi | ted | | | | | | 1 L Ye | es 2.⊒+Mo 3.□ | Probably 4 Unknown |
| e taw | Completed | | | | | | 24a. Was a autops | sy prior | autopsy findings available to completion of cause of |
| r. The | | | | | | | perfórr 1 ☐ Yes | | 1? ∕es 2□ No |
| Physicien: The law this certificate has t al director, page 2 s | Be | 25. Was case referred to medical examiner? | ospital: | | Othe | | th (Check only on | | |
| Phys r this ral di | To I | 1 ☐ Yes 2 ☐ Mo '' 27. Manner of Death | 1 Inpatient 2 E | R/Outpatient 28b. Time of | 3 DUA | 4 Mursing Ho | | ence 6 Other (S | Specify) |
| el or Attending Pisatter death. I Director: After tid in by the funera | tlor | 1 Destural 5 Pending 2 Accident investigation | (Month, Day Year) | Injury | 28c. Injury Work M 1 □ ` | res 2 □No | | on many occanios | |
| Atter r dea ector by the | ifica | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At hom building, etc. (Specify) | ne, farm, stre | et, lactory, office | | | | Rural Route Number, |
| s afte | Certification; | 4 _ Hollicide | building, etc. (Specify) | | | | City or Towr | n, State) | |
| Hospir 4 hour Funer ely fill | | Check only 2 Medicel Exemit | icien: To the best of my know er: On the basis of examination | ledge, death | occurred at the timestigation, in my of | ne, date and place, pinion, death occur | and due to the cared at the time, d | ause(s) and manner ate and place, and o | r as stated. due to the cause(s) |
| To the Hospitel or Attending Phyeicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical | one) 29b. Signature and title of certifier/ | and manner stated. | | 29c. License | | | 9d. Date signed (Mo | |
| F3F3 | | 1 200 /1 | | | 0- | 207 | p | 11/9/ | , , , , , , |
| (K) | | 30. Name and address of person who co | moteted cause of death (Item) | 23a) (Tuna 1 | Print) | 1)54 | / | 4// | 71 . |
| X | | WILLIAM ROBINS, M | | | , | DV. MD | 21804 | | |
| Sta | ite | 31. Date liled (Month, Day, Year) | 32. Registrar's Signatu | ire | | MI CID. | STAC4 | | |
| Registr | ar | NOV 1 4 2 | 2005 May 1 | H. | Somet ! | | | | |

| | | | 1 - For State Registrar | | laryland . | | tificate of | lealth and M Death | | Reg. No. | 105 | 38133 |
|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------|--------------------------|---------------------------------------------------------|-----------------------------------------------------|---------------------------------------|-----------------------|-------------------------------------------------|----------------------------------------------|
| | Physici | ian | Decedent's Name (First, Middle, Last | • | | | | | 2. Date of D | | 2005 ^{ar} | 3. Time of Death |
| | /Media | cal | Norman Stanley 4a. Facility Name (If not institution, give | · | -1 | | 45 03 T | | 1 | | | 5:10 a |
| | Examir | ner | Westminster Nurs | | | scent | | r Location of Death minster | 1 | 46.0 | Carroll | |
| | Funeral Director | | | 9x 7. A | nge (In yrs. last 77 | birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bi (Month, D | ay, Year) | Coui | place (State or Forei ntry) MD |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, T | own or Loc | cation | | | | 1 | l0d. Inside City Limi |
| | Mary -1 sho | ţ | MD Carrol | 1 | | Taney | town | | | | | 1 □Xes 2 □ N |
| | h the | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citize | en of What Cour | ntry? |
| | 23e c | aiD | 211 E. Baltimore | Street | | | | 21787 | | | USA | |
| 2 | 72 hours after death with the Maryland "neturel", or Items 23e or 28e-1 show offset Exemitrer must be notified at | by Funerai | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Was Deceden Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates | i?]No | | Vas Decedent of H Yes, specify Cuba □ Yes 2 □ ★ o | lispanic Origin? (Span, Mexican, Puerto Specify: | pecify Yes or N o Rican, etc.) | | 4. Race - Americ Black, White, Specify: W | |
| Z1Z13-0030 | 2 hou | led | 15. Decedent's Ed | lucation | | 6a. Deced | ent's Usual Occup | ation | | 16b. Kind | d of Business/In | dustry |
| 3 | within 73 ene. than "no | Completed | (Specify only highest gra | de completed) College (1-4or | | (Give I life. D | kind of work done i OO NOT use retired | during most of world) | king | | | - |
| 7 | filed wil Hygien ther th | Con | 8 | | | Ма | intenanc | | | | | rporation |
| Maryland | ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 Is marked other than "neture or other treumatic event, the M. Lictal | To Be | 17. Father's Name (First, Middle, Last) Norman Carroll Ra | | | _ | | 18. Mother's Nam Marjori | ne (First, Middle Le Wort) | | | |
| 0 | and ls me | | 19a. Informant's Name/Relationship (| Type, Print) | | | | and Number or Ru | ral Route Numb | er, City or | Town, State, Zip | Code) |
| ≥ 'î | and lealth m 27 | | Connie Carbaugh/d | aughter | OOS Disc | | ockland | | stminste | | | |
| 5 | ges 1 If ite or of | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ | | e 200. Place | etery, crem | sition (Name of patory or other place | (8) | Date | 20c. Loca | ation - City or To | own, State |
| Dalilliore, | permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any njury or other tre ance. | | * 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Servication Licer | | Lake | 22. | Name and Addre | 1 Pk 11/(ss of Facility neral Hon | | | | MD |
| | 207299 | | 1 /2 /- /- /- /- /- /- /- /- /- /- /- /- /- | 7 | | 1000 | | | | | | 21157 |
| | Physician | | 23a. Par1. Enter the disease, or com sock, or heart failure. List only Immediate Cause (Final disease or condition | plicalities that cause one cause on each | ed the death. It line. | Oo not ente | My O hat | ig, Tuch as cardiac Try Diseas | or respiratory a | ırrest, | , | Approximate Interval Between Onset and Death |
| | /Medical Examiner | П | resulting in death) | Due to (or a | s a consequen | ce of): | 1 | X - | | | | - 100 |
| | | i. | Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or a | COYJUA | oppi): | mery | Wiseau | C | | - | 2 9000 |
| | tuted id ansit | Examin | Cause. Enter Underlying Cause (Disease or injury that initiated events | C | | ' | | | | | | |
| ,00700 | ificate be executed g physician and as the burial-transit | ai Exa | resulting in death) Last | Due to (or a | s a consequen | ce of): | | | | | | |
| 000 | T 70 # | edicai | | . a. | | | | | | | | |
| .O. DOX | e death cert the attendin hed for use | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | e of pregnancy 2 Fetal de at time of death | ath 3 🗌 | Ectopic pregnancy Other (specify) | , | | 23 | Bd. Date of delive Month | ery Day Year |
| _ | uires that th signed by d be detacl | by | Part II. Other significant conditions of | ontributing to death | but not resultin | ng in the un | derlying cause give | en in Part I. | | tobacco use | | ne cause of death? |
| Records, | w requir been si should I | iete | | | | | | | 24a. Was | | 24h Wasa auta | nov findings availab |
| ב ב | The lav | Completed | | | | | | | auto perf | psy ormed? | prior to cor death? | psy findings availab npletion of cause of |
| VIId | 40 17 | 0 | 25. Was case referred to medical | <u> </u> | | | | 26. Place of Deal | | 2 No | 1 ☐ Yes | 2 No |
| > | 8 8 | To B | examiner? 1 Tes 2 No | Hospital: | tient 2 ER | /Outpatient | 3□ DOA Dth | | | | ☐Other (Specify | <i>(</i>) |
| on or | Jing After fune | | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of In (Month, D | iury 28 | b. Time of Injury | 28c. Injun World | | 28d. Describe | | | , |
| UIVISION | To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of II | njury - At home etc. <i>(Specify)</i> | , farm, stre | eet, factory, office | | | Street and wn, State) | Number or Rura | I Route Number, |
| | To the Hospitel or within 24 hours afte To the Funeral Dirr completely filled in 1 | Medical C | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | ysician: To the bes niner: On the basis and manner s | of examination | dge, death and/or inv | occurred at the tin estigation, in my o | ne, date and place, pinion, death occur | , and due to the rred at the time, | cause(s) ar | nd manner as st lace, and due to | ated. the cause(s) |
| | To th within To the | Me | 29b. Signature and title of certifier | 11- | | | 29c. License | e number | | 29d. Date | signed (Month, | Day, Year) |
| | NEW | | > Chacle | MD | | | | 52035 | | Nou | 5 | 2005 |
| | v 5 | | 30. Name and address of person who BINU CHACIC | 201 | | 4 | A 22 | e we | nt mini | sty | MD 21 | 157 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Regi | trar's Signature | | , | | | | | - |
| 21.11 | Regist | · | NOV 0 7 | 2005 | due) | G. J. | parle | | | | | |
| иΗ | VIH 17 Rev 1/2 | 2001 | | - | | - | | | | | | |

| | | - | | partment of Health and Mertificate of Death | | ene) 05 | 38134 | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------|----------------------------------------------------|--|
| | Physici: /Medic | an | Decedent's Name (First, Middle, Last) JOSEPH COY SHEPHERD | | 2. Date of Death Month NOVEMBER | 2005° | 3. Time of Death 3:19 PMM | |
| ı | Examin | | 4a. Facility Name (If not institution, give street and number) CARROLL HOSPITAL CENTER | 4b. City, Town, or Location of Death WESTMINSTER | | 4c. County of Dea | | |
| | Funeral Director | | 5. Social Security Number 212–20–9518 Sex XX M 2 F 83 Yrs. | y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day,) JULY 4, | 9. Bir 1922 N | thplace (State or Foreign OUTH CAROLIN | |
| | Maryland -f show | tor | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MARYLAND CARROLL HAMPST | | | 10d. Inside City Limits 1 □ Yes 2 📆 🖔 o | | |
| | th with the | ai Direc | 10e. Street and Number 4418 BLACK ROCK ROAD | 10f. Zip Code 21074 | 109 | Citizen of What Country? UNITED STATES | | |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show ways injury or other treumatic event, Ite Marical Examinate Landined at Stock. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 1 Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto □ Yes 2☑No Specify: | pecify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | | |
| Maryland 21215-0036 | d within 72 ho giene. Ir then "natur Ine Modical | Completed | (Specify only highest grade completed) (Gi | cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired) LABORER | ring | 6b. Kind of Business | | |
| land | uld be file dental Hyg rked othe tic event, | To Be C | 17. Father's Name (First, Middle, Last) JACK SHEPHERD | 18. Mother's Nam | e (First, Middle, Ma FRYE | aiden Sumame) | | |
| , Mary | ind 2 short alth and N 27 Is ma or treums | | | ailing Address (Street and Number or Rur D ¹ BRIEN AVENUE, TA | nal Route Number, NEYTOWN, | | | |
| Baltimore, | Pages 1 and the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of the perferment of | | 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State | rematory or other place) | 10/2005 | Oc. Location - City of | Town, State | |
| Balt | permit. Departitions in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate in incorporate | | Thought I some | 22. Name and Address of Facility YYERS-DURBORAW FUNE 91 WILLIS STREET, | WESZMINS | STER. MD | 21157 | |
| | Physician /Medical Examiner | ner / | 23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | | or respiratory arres | | Approximate Interval Between Onset and Death | |
| 8760, | death certificate be executed e attending physician and of for use as the burial-transit | dical Exam | Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | | |
| P.O. Box 6 | that the death certific ed by the attending p detached for use as ' | hysician/Me | | 3□Ectopic pregnancy 5□ Other (specify) | | 23d. Date of de Month | olivery Day Year | |
| Ś | g g | by P | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | | | o the cause of death? | |
| Division of Vital Record | The law ate has b page 2 sl | Be Completed | Chronic Obstruction Profilm and Profit more 25. Was case referred to friedical examiner? | | 25a. Was an autopsy perform 1 Yes 2 | ed? prior to death? | | |
| sion of V | ing Phye | Certification: To | 1 | e of 28c. Injury at Work? M 1 Yes 2 No | 28d. Describe hov | nce 6 Other (Spender injury occurred least and Number or F | | |
| Dİ | r A ter ter po | | 4 Homicide determined building, etc. (Specify) | | City or Town, | State) | | |
| | To the Hospitel or within 24 hours at To the Funerel D completely filled in | Medical | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, do (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier | | rred at the time, dat | | e to the cause(s) | |
| | 3 | | Hafees A / Steel 1 | 1.D D25052 | 2 6 | 1/7/0 | 75 | |
| | cho | | 30. Name and fiddress of person who completed cause of death (Item 23a) (Ty 11. Date filed (Month, Day, Year) 32. Registrar's Signature | DOS SKORES I | or, MI | 1/3 2 | 1136. | |
| | St Regist | ate rar | NOV 1 0 2005 See & | Sporte | | | | |

| | | | 1 - For State Registrar | State of M | aryland | | artmen tificate | | | | В | eg. 12. 0 0 | 5 | 38135 | |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------|--------------------------------|-----------------------------------------|-----------------------------------|---------------------------------------|--------------------------|--------------------------------------------|------------------------------------|-----------------------------------------------|----------------------------------------------|--|
| ı | Physici | | 1. Decedent's Name (First, Middle, La Clinton Will | | th II | | | | | | 2. Date of Dea Novemb | | 003 | 3. Time of Death 6:15P M | |
| | /Medio Examir | | 4a. Facility Name (If not institution, given Citizens Nursing) | | | | 4b. City, | | Location o deric | k | | | 4c. County of Death Frederick | | |
| | Funeral Director | | 5. Social Security Number 6. S 215-14-2000 Susual Residence of Decedent | Sex 7. Ag | e (In yrs. la 84 | est birthday) Yrs. | If Under Months | 1 Year Days | If Under 2 Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day Mar. 20 | , 1921 | 9. Birthp | place (State or Foreign ntry) ryland | |
| | ryland how | | 10a. State 10b. County | | 10c. City, | , Town or Lo | | | - L | | | | 1 | 10d. Inside City Limits | |
| | the Ma | Director | Maryland Frede | rick | | | 10f. Zip | | sboro | | | Og. Citizen of N | What Cour | 1 ☐ Yes 2 ☐ No | |
| | 23a or | ai Dir | 11108 Dublin | Rd. | | | Tot. Zip | Code | 217 | 98 | | | S.A. | itry : | |
| 9800 | nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland content of Health and Mental Hyglene. ortant: If item 27 is marked other than "naturel", or items 23a or 28e-f show injury or other traumatic event, ite Medical Exalt naturalize indifficulation. | by Funeral | 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates: | No | | Vas Deced f Yes, spec | | spanic Orig n, Mexican Specify: | gin? (Spec , Puerto F | cify Yes or No- Rican, etc.) | | ck, White, | can Indian, etc. hite | |
| 15-0 | in 72 h "natu edicul | oletec | 15. Decedent's E (Specify only highest gra | ade completed) | | 16a. Deced (Give life. I | lent's Usua kind of wor DO NOT us | l Occupa k done d e retired | ition luring most) | of workin | ig | 16b. Kind of B | usiness/In | dustry | |
| 212 | er thar | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | | | | work | er | | const | | ion | |
| Maryland 21215-0036 | 12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Men | To Be | 17. Father's Name (First, Middle, Last William Clinto | n Smith | | | | | С | arri | (First, Middle, I | oung | | | |
| | nd 2 sh ilth and 27 is m r traum | | 19a. Informant's Name/Relationship (Clinton W. Smith | ** | | | | | n Rd. | | Route Number Wood s | r, City or Town, boro,M | | | |
| Baltimore, | permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once. | | 20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ | Removal from State | ce | ace of Dispo metery, cren | natory or or | ther place | | | | 20c. Location - | | | |
| ıtim | permit. Pag Depertment Important: I any injury c | | ' 4 ☐ Donation 5 ☐ Other (Special 21. Singlet Legentre Light 1997) | | Roc | | | | - 1 | | 2005 n zler Fu | | | o, MU | |
| Ä | permit. Departr Importa any inji | | (athania) |). Harre | en | | | | in St | | Woodsb | oro, MC | 217 | 98 | |
| | Physician /Medical Examiner into pural-transit the printing form | Examiner | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as | a conseque | | a C | and | ist | bul | n d | Isine | , | Approximate Interval Between Onset and Death | |
| 68760, | ficate by physicas the by | edica | | d | | | | | | | | | | | |
| .O. Box | The law requires that the death centificate be executed the has been signed by the attending physician end hage 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal | death 3 | Ectopic pro | | | | | 23d. Dai Mo | te of delive | ery Day Year | |
| Records, P. | w requires that been signed b should be deta | by | Part II. Other significant conditions of | contributing to death b | ut not resul | lting in the ur | nderlying ca | ause give | on in Part I. | | 23e. Did tol | _ | ribute to th | ne cause of death? | |
| I Reco | | Completed | | | | | | | | | 24a. Was a autops perform | ned? | Were auto prior to co death? i □ Yes | psy findings available mpletion of cause of | |
| Vital | Physicien: Th this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? | Hospital: 1 ☐ Inpatie | not 2 🗆 C | R/Outpatien | t 3 🗆 DQ | . Othe | 4 | | (Check only on e 5 □ Reside | | (0 | | |
| ion of | ding After fune | I- | 27. Manner of eath 1 Natural 5 Pending 2 Accident investigatio | 28a. Date of Inju (Month, Da | iry : | 28b. Time of Injury | | Bc. Injury Work | ar | 21 | 8d. Describe ho | | | " | |
| Division | or A | Certification; | 3 Suicide 6 Could not be determined | e 28e. Place of Inj building, et | ury - At hon c. (Specify) | ne, farm, str | eet, factory | , office | | 20 | 8f. Location (St City or Town | reet and Numb n, State) | er or Rura | I Route Number, | |
| | Hospi 24 hou Funer stely fill | Medical | 29a. Certifying Pt (Check only one) | nysician: To the best miner: On the basis o and manner st | f examination | rledge, death on and/or inv | occurred a restigation, | at the time in my op | e, date and inion, deat | d place, ar h occurre | nd due to the ca d at the time, d | ause(s) and ma ate and place, a | nner as st and due to | ated. the cause(s) | |
| | To the Hospitel within 24 hours a To the Funerel completely filled | Me | 29b. Signature and title of certifier | 2011 | | | 29c | . License | number | | 2 | 9d. Date signed | (Month, | Day, Year) | |
| • | MJL | | Mary Z. | Mary | un | 020) (7 | |)-I | 139 | 7/ | | 1/7 | 105 | | |
| | . 6 | 2 | 30. Name and address of person who Robert L. Kauf | | | 23a) (Type, 00 W. | | t. | Fred | eric | k, MD 2 | 1701 | - | | |
| F | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 0 8 | | ar's Signatu | ure K | Cast. | , | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joseph John Skiba, Jr November 2005 10:00 p /Medical 4 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2171 Green Mill Road Finksburg Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 126-28-4794 1 □ MM 2 □ F 69 Director Oct 9 1936 NY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show a piner roust be notified at 10d. Inside City Limits MD Carroll Finksburg 1 ☐ Yes 2 ☑ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2171 Green Mill Road 21048 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1- Yes 2□No 1955-Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: White 3 Widowed 4 Divorced 1959 Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Black and Decker Pages 1 and 2 should be filed vent of Health and Mental Hygie int: if item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Joseph John Skiba, Sr Anna Pleskum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2171 Green Mill Road Finksburg, MD Aimee Newhall/daughter 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11/07/2005 Department of the Important: If its any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21157 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LOVER Weterfusin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last ettending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Dougther examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1, Vatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29a. Certifier Medica (Check only investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WSL 6+14 30. Name and address of person who completed cause of death (Item 23a) Type, Pint)

State Registrar

DHMH 17 Rev 1/2001

Gorde

32. Regionar's Signature

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2005

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31. Date filed (Month, Day, Year)

| | | | 1 ≈ State Registrar | State of Maryland / | Department of Certificate of | | | giene 05 | 38137 |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------|--------------------------------|---------------------------------|--------------------------------------|----------------------------------------------|
| | District Co. | | 1. Decedent's Name (First, Middle, Last) | | | | 2. Date of De | | 3. Time of Death |
| | Physici /Medic | | Charles | Ralph Staffo | rd, Sr. | | Novembe | | |
| | Examin | | 4a. Facility Name (If not institution, give s | | | or Location of Death | | 4c. County of De | ath |
| | | | 9314 Mike Street | | Dento | | | Carolin | ne |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last b | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | v, Year) | irthplace (State or Foreign Country) |
| | Director | | 216-14-2766 | 83 | Yrs. | | December | 30, 1921 Ma | aryland |
| | and | | Usuat Residence of Decedent 10a. State 10b. County | 10c. City, To | wn or Location | | | | 10d. Inside City Limits |
| | Aaryl sho | ō | | D | + | | | | 1 □Yes % □No |
| | the 28a- | Director | Maryland Carol 10e. Street and Number | The Der | nton 10f. Zip Code | | | 10g Citizen of What (| Country? America |
| | with Sa or | | | | 216 | 20 | | United St | |
| | filed within 72 hours after death with the Maryland Hyglene. ther then "natural", or flams 23a or 28a-f show ther then matural arminer must be notified at | Funeral | 9314 Mike Street | 12. Was Decedent Ever in U.S. | 13. Was Decedent of | | | | |
| (0 | r ftar | F | 1 ☐ Never Married 2 ☐ Married | Armed Forces? | If Yes, specify Cut | oan, Mexican, Puerto | Rican, etc.) | Black, Wh | nite, etc. |
| 8 | ali, o | by | ¥☐Widowed 4 ☐Divorced | If Yes, Give Year or Dates: 1945 | 1 ☐ Yes 2√2 No | Specify: | | Specify: | ıcasian |
| 21215-0036 | 72 ho | Completed | 15. Decedent's Educ (Specify only highest grade | cation 16 | a. Decedent's Usual Occu (Give kind of work done | pation | ina | 16b. Kind of Busines | |
| 2 | thin . | npie | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NOT use retire | ed) | n ig | | |
| 2 | ygien ygien ygien t, the | S | 6 | | Carpenter/ | | | Constru | ction |
| lud | be fill d of t | Be | 17. Father's Name (First, Middle, Last) | | | | | Maiden Sumame) | |
| <u> </u> | should and Men s marke umatic | ၉ | | k Malone Staf | | | | zabeth B | |
| Maryland | s 1 and 2 should be filed within 72 hours after death with the Marylan if Haulth and Mental Hyglene. Item 27 is marked other than "natural", or frams 23a or 28a-1 show other traumatic event, the Mardical Examiner must be notified at | | 19a. Informant's Name/Relationship (Type | | b. Mailing Address (Stree | | | | |
| | of Health ar item 27 is other trau | | Jennie S. Towe | | 8811 Mito | | ad, De | | |
| Ore | Pages 1 nent of H int: if ite iry or ot | | 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ R | 1 0000000 | ery, crematory or other pla | 100) | | 20c. Location - City of | |
| Ë | tmen tant: | | '4 ☐Donation 5 ☐ Other (Specify) | | on Cemeter | | 7/2005 | | , Maryland |
| Baltimore, | permit. Pages 1 and Department of Heall Important: if item 2 any injury or other once. | | 21. Signature of Funeral Service License | 27 | 22. Name and Addr Moore Fi | ess of Facility uneral Ho | ome, P | .A. | 21629 |
| | 402 6 0 | | 17 quely 11 L | 100- | 12 Sout | n Second | Stree | t, Dentor | n, Maryland |
| | | | 23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on | e cause on each line. | | ing, such as cardiac o | or respiratory a | rrest, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | YULMONARY | FIBROSIS | | | | 18 MONTHS |
| | Examiner | | | Due to (or as a consequence | e of): | | | | |
| ш | | ē | Sequentially list conditions, b | . Due la la a consequence | 9 Of). | | | | |
| | uted 1 Insit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | · | , | | | | |
| <u>,</u> | exect n and ial-tra | Exa | that initiated events cresulting in death) Last | Due to (or as a consequence | e of): | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | dicail | | | | | | | |
| 9 | lificat ig phy as th | 0 | | | | | | | |
| Вох | h cer endin use | N/ | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregnancy | h 3∏Estania svogasa | | | 23d. Date of d | elivery |
| | that the death certif ed by the attending detached for use a: | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 Live birth 2 Fetal deat 4 Pregnant at time of death | th 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _ | <u>.</u> | | Month | Day Year |
| 0 | t the by th tache | hys | 9 □ Unknown | 9□ Unknown | | | | | |
| S, D | res tha igned be del | by F | Part II. Dther significant conditions con | tributing to death but not resulting | in the underlying cause gi | ven in Part I. | 23e. Did t | obacco use contribute | |
| ğ | w require been sig should b | ed | | | | | 1 🗆 🗅 | res 2□No 3□F | robably 4 Whiknown |
| CC | e taw re has be je 2 sho | Completed | | | | | 24a. Was | an 24b. Were a | autopsy findings available |
| ď | The lite has | mo: | | | | | autor perfo | rmed? death? | completion of cause of s 2□ No |
| Vital Records, | | a | 25. Was case referred to medical | | | 26. Place of Death | | | 5 2010 |
| | Physician: rthis certific ral director, | To B | examiner? | ospital: 1 Inpatient 2 ER/C | Outpatient 3 DOA Ot | her: 4 Nursing Ho | me 5 Resid | dence 6 ☐Other (Sp | ecify) |
| 0 | ng Phy ter thi | | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) 28b. | Time of 28c. Injury Wo | ry at | | now injury occurred | |
| 0 | Attending ir death. ector: After by the fune | atic | 2 Accident investigation | | | Yes 2 No | | | |
| Division of | r Atte | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At home, I building, etc. (Specify) | farm, street, factory, office | | 28f. Location (S City or Tox | Street and Number or F vn, State) | Rural Route Number, |
| | ital or irs afte rai Dire led in b | | | | | | | | |
| | Hospi thon une une | edical | 29a. Certifier Certifying Phys | sician: To the best of my knowledger: On the basis of examination a | ge, death occurred at the tand/or investigation, in my | me, date and place, | and due to the | cause(s) and manner a | is stated. |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medi | one) | and manner stated. | | | | | |
| | To To | | 29b. Signature and title of certifier | | 29c. Licen | | | 29d. Date signed (Mor | th, Day, Year) |
| | | | | | | 53815 | | 11/14/0 | 0 03 |
| | | | 30. Name and address of person who co | | | | | ' / | 2.04.620 |
| | - 01 | | Korah M. Pulimo | od, M.D., 912 | Market S | treet, D | enton, | Maryland | 21629 |
| | Sta | te ar | NOV 1 5 2005 | 32. Registrar's Signature | Constate 1 | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year ROBERT BRUCE SURFUS NOVEMBER /Medical 13 2005 6:55pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □XM 2 □ F Director 309-34-6759 69 MAR.1,1936 MICHIGAN Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show treumatic event, the Medical Exertaner must be notified at 10d. Inside City Limits MARYLAND CHARLES Director WALDORF 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 10412 CASSIDY COURT Funeral 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XXes 2 □ No If Yes, Give Year or Dates:1959 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0 þ 1 Yes XXNo Specify: 3 ☐ Widowed 4 ★ ivorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STORE MANAGER RETAIL SALES land permit. Pages 1 and 2 should be fil. Department of Health and Mental Hy Important: If Item 27 is marked oth any liqury or other treumatic even QDGs. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES SURFUS MARJORIE SURFUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICK SURFUS-BROTHER 10412 CASSIDY CT., WALDORF, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial ZX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ME METROPOLITIAN CREMATORY 11-16-05 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** river Zi10 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the attending physicien and ched for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No 2 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No P Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DH-0058095 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONYA L. HARDY MD 11345 PEMBROOKE SQUARE WALDORF MARYLAND 20603 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 2 8 2005 Registrar DHMH 17 Rev 1/2001

Physician /Medical Examiner siclan and bunial-transit Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

2

Completed

Funeral

Director

with the Marylend

Maryland 21215-0020

Baltimore,

Medical Certification: To Be Completed by Physician/Medical Examiner

| disease or condition resulting in death) | · congestive t | reart tailure | | lyear |
|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------|
| , and the second | Due to (or as a consec | quence of): | | |
| | , aortic ster | nosis | | iyears |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec | | | |
| Cause (Disease or injury that initieted events resulting in deeth) Lest | C. Due to (or as a conseq | quence of): | | |
| | d | | | |
| Part II. Other significant conditions of | ontributing to death but not resulting in the u | inderfying cause given in Part I. | 23b. Did tobacco use co | ontribute to the cause of death? |
| diabetes me | Ilitas | | 1 □ Yes 2 🔾 No | 3 Probably 4 Unknow |
| Osteoporosi | \$ | | 24a. Wes an autopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
| | | | 1 □ Yes 2 No | 1 ☐ Yes 2 ☐ No |
| 25. Wes case referred to medical | | 26. Place of De | ath (Check only one) | |
| examiner? | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier | nt 3 DOA Other: 4 Nursing I | Home 5 ☐ Residence 6 ☐ Oth | her (Specify) |
| 27. Manner of Death 1 Statural 5 ☐ Pending 2 ☐ Accident investigation | | of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occur | rred |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Plece of Injury - At home, farm, str building, etc. (Specify) | reet, factory, office | 28f. Location (Street and Numb City or Town, State) | ber or Rural Route Number, |
| | yelclan: To the best of my knowledge, death Iner: On the besis of examination and/or in end manner stated. | | | |
| 29b. Signature end title of certifier | | 29c. License number | 29d. Date signe | ed (Month, Day, Year) |
| 1 Centhia 1 | Lutters - Sanda | mo D47451 | Novem | ber 18,2005 |

154 North Aftizan Street

Williamsport Nursing Home, Williamsport, Maryland

Registrar **DHMH 16 Rev 6/95**

State

within 24 hours after death To the Funeral Director: completely filled in by the

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

2005

ands MD

Cynthia Kutthe

NOV 2 8

31. Dete filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Yeer \mathbf{P}^{M} Nov. David Tabler 2005 6, 7:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mt. Airy

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Pleasant View Nursing Home Carroll 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⋈**M 2□F Director 213-12-8151 84 2, 1921 Feb. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funerai 437 Woodbine Road 21797 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Types 2 No If Yes, Give Year or Dates: W.W.T. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 28 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) 8 Disabled Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas ပ Tabler Marion Warthen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Janet Tabler wife 437 Woodbine Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Depertment of injury or 4 ☐Donation 5 ☐ Other (Specify) Morgan Chapel Cem. Nov. 10, 2005 Woodbine, MD 22. Name and Address of Facility 1212 W. Old Liberty Road 21784 Burrier-Queen Funeral Home & Crematory, FA 21. Signature of Funeral Service Licenspe amu Part1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attanding Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Thursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred ...er death. ...eral Director: After y filled in by the * 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) MA MSI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 culwell Dr. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

| | | | 1 - For Stete Registrar | | State of | of Marylar | | artmen <i>rtificati</i> | | | and M | • | giene | DOOF | , | 381 | 1, 2 |
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| | | | Decedent's Name (| First, Middle, La | ist) | | | | | | | 2. Date of De | | <i>.</i> 0 0 0 | | 3. Time o | f Death |
| | Physici | | Doro | thu | | And | rev | 1.75 | lson | | | Month | Da | | ar | | М |
| | /Medic Examin | | 4a. Facility Name (If n | | ve street and nu | | теу | | | Location of | of Death | Novembe | | 2005 County of D | eath | 5:15 | 1 |
| 1 | LAGIIIII | E: | Allegany Co | unty Nurs | ing and H | Rehab. Ce | nter | C | umber | land | | | | Allegar | | | |
| | Funeral | | 5. Social Security Num | | Sex | 7. Age (In yrs | | If Under | 1 Year | If Under | | 8. Date of Bir | th | | | ace (State | or Foreign |
| | Director | | 218-12-5171 | | 1□M 2∏F | 81 | Yrs. | Months | Days | Hours | Min. | (Month, Da 03/06/1 | | | | | |
| | g | | Usual Residence of D | | | | | | | | | | 7.4- | - 116 | ryla | | |
| | ehow | | 10a. State 1 | 0b. County | | 10c. C | ity, Town or Lo | ocation | | | | | | | 10 | d. Inside C | • |
| | the Ma | cto | MD | Alle | gany | | | Cumber. | land | | | | | | | 1 🔲 Yes | 2 ∏ No |
| | or 28 | Director | 10e. Street and Numb | | | | | 10f. Zip | | | | | 10g. Ci | tizen of What | Count | ry? | |
| | th w | | 13013 | 3 Acre La | ne, NE | | | | 215 | 02 | | | Ü | ISA | | | |
| | | Funeral | 11. Marital Status | | 12. Was Dec | edent Ever in l prces? | | Was Deced | dent of Hi | ispanic Origin, Mexican | gin? (Spe , Puerto | ecify Yes or No Rican, etc.) | - | 14. Race - A Black, W | | | |
| 36 | or it | by Fu | 1 Never Married | | 1 ∐ Yes If Yes, Gi | ve î | | 1 ☐ Yes | 2 X] No | Specify: | | | | Specify: | | | |
| 8 | 72 hours after "natural", or ite | | 3 Widowed 4 | | Year or E | oates: | 1 40- D | d | 10 | | | | 120 | | | hite | |
| 7 | n 72 | Completed | | Decedent's E only highest gr | | | (Give | dent's Usua kind of wor DO NOT us | nk done d | ation during mosi | t of worki | ing | 16b. K | (ind of Busine | ss/Indi | istry | |
| 12 | within ene. than " | E . | Elementary/Second | lary (0-12) | College (| 1-4or 5+) | | Clerk | , , , , , , , , , , , , , , , , , , , , | , | | | Don | artment | Sto | * 0 | |
| 2 | filed Hygi ther ant, I | ပိ | 17. Father's Name (Fi | rst, Middle, Las | t) | | · · · · · · · · · · · · · · · · · · · | GIEIK | | 18. Mothe | r's Name | (First, Middle, | _ | | 310 | I.E | |
| Maryland 21215-0036 | s 1 and 2 should be filed within 72 hc Fleath and Mental Hygiene. Item 27 is marked other than "natural other traumatic event, Ital Medical | 8 | Lester | | Port | er | Mil | ler | | Soph | ie | | Y | eager | | | |
| <u></u> | shoul nd Me mark mati | 2 | 19a. Informant's Nam | e/Relationship | (Type, Print) | | 19b. Maili | na Address | (Street a | and Numbe | r or Rura | Il Route Numbe | er. City o | or Town. State | a. Zip (| Code) | |
| Z | d 2 s th ar 27 is trau | | Willys L. Wi | | | | | • | • | | | erland, N | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| ā, | permit. Pages 1 and 2 Department of Health a important: If item 27 it eny injury or other tra | } | 20a. Method of Dispos | | aspana | 20b. | Place of Dispo | sition (Nan | ne of | Ţ | | Date | | ocation - City | | n, State | |
| Baltimore, | ages ant of t: If i | | 1 ☐ Burial 2 ☒ 1 | | | State | cemetery, crea | | | 1 | . / / | | | | | | |
| ≢ | artme ortan injur | } | 21. Signature of Fund | | | Cı | mberlan | d Crema 2. Name an | | | 1/10/ | | | erland, | | | |
| Ba | Depariment of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of the permit of th | | Lad | us (| . Cer | Lene | . / | | | | , Mu | ams Famil mberland, | | | , | | |
| | | | 23a. Part1. Enter the shock, or heart f | disease, or con | nplications that | caused the dea | | | | | | | | y Ianu | | Approximat | te |
| | | | shock, or heart f Immediate Cause (Fi | | 2 | | CIRI | | | | | , | | | | Interval Bet Onset and | |
| | Physician /Medical | | disease or condition resulting in death) | | - u. | IVER | | \n-O. | 213 | | | | | | - | 104 | cors |
| | Examiner | | | - 1 | 509 (0 | (or as a conse | quence or): | | | | | | | | | | |
| | | e e | Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or inj | itions, ediate | b | (or as a conse | quence of): | | | | | | | | + | | |
| | uted d ansit | Examiner | cause. Enter Underly Cause (Disease or in) that initiated events | ring ury | | | | | | | | | | | | | |
| Ć, | be executed ician and burial-transit | Exa | resulting in death) Las | st | Due to | (or as a conse | quence of): | | | | | | | | + | | |
| 8760, | cate be execu physician and the burial-tra | dical | | • | d | | | | | | | | | | | | |
| 68 | | ⊕ † | | | | | | | | | | | | | | | |
| Вох | death certific e attending p id for use as | Physician/M | IF FEMALE: 23b. Was decedent p | regnant | | tcome of pregn | | Ectopic pr | | | | | | 23d. Date of | deliver | y | |
| Ω. | | Cia | in the past 12 mg | | 4☐Preg | oirth 2 ☐ Feta nant at time of a | | Other (sp | | | | | | Month | | Day | Year |
| P.O. | that the death ed by the atte detached for | hys | 9 🗆 Unknown | | 9□ Unkn | own | | | | | | | | | | | |
| | requires that the een signed by the rould be detache | by P | Part II. Other significa | | | | sulting in the u | nderlying ca | ause give | en in Part I. | | 23e. Did to | obacco | use contribute | to the | cause of o | death? |
| ğ | w requires been sign should be | ed | _ HRO | MBOC | . YTOPE | ENIA | | | | | | 101 | res e | □ 10 3 □ | Probai | oly 4 ⊟i | Unknown |
| Š | e law requ has been je 2 shoul | Completed | | | | | | | | | | 24a. Was | | 24b. Were | autops | sy findings | available |
| æ | The late has page | E O | | | | | | | | | | perfo | med? | death | ? | PIOLIOIT OF C | 2030 01 |
| ā | iician: Th certificate rector, pag | Bec | 25. Was case referred examiner? | d to medical | | | | | | 26. Place | of Death | (Check only o | | | | | |
| > | S 0 70 | To | 1 Yes 2 No | 5 | Hospital: 1 🗆 | Inpatient 2 |] ER/Outpatier | nt 3 DO | Othe | 27: 41□ Nu | rsing Hor | me 5 Resid | dence | 6 □Other (S | pecify) | | |
| 0 | ding Phy h. After thi funeral | | 27. Manner of Death | 5 Pending | 28a. Date (Mor | of Injury th, Day Year) | 28b. Time o | 2 | 8c. Injury Work | at c? | : | 28d. Describe h | now inju | ry occurred | | | |
| Division of Vital Records, | auth. or: Ai | Certification: | 2 Accident | investigation | n | | | М | | Yes 2□1 | No | | | | | | |
| <u>≅</u> | r Att | ₩ | 3 🔲 Suicide 4 🔲 Homicide | 6 Could not to determined | 286. Place | of Injury - At hing, etc. (Speci | iome, farm, str | eet, factory | , office | | 1 | 28f. Location (S City or Tox | Street ar vn, State | nd Number or e) | Rurai | Route Num | nber, |
| D | ital c irs at rai Di led ir | | | | | | | | | | | | | | | | |
| | To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral | icai | (Check only 2 | Certifying P Medicel Exa | miner: On the b | asis of examina | owledge, deatl ation and/or in | n occurred a | at the tim | e, date and pinion, deat | d place, a | and due to the o | cause(s) | and manner diplace, and c | as stat | led. he cause(s | 5) |
| | the the the | Medicai | one) | | and man | ner stated. | | | License | | | | | | | | |
| | To wit | - | 29b. Signature and titl | e or certaler | 1. Chot | aui. | | | | 853 | | | | te signed (Mo | | | |
| | 3 | | | | | | | | | | | | / (| 1/8/0 | > | | |
| | MLS | | 30. Name and address | | completed cau | se of death (Ite | m 23a) (Type, | Print) | 5 41 | I/A.KI | IA | AVE, | C | UMB | ER | LAN | D. MA |
| | | | 31. Date filed (Month, | | | Registrar's Sign | aturo | | | V/(7V | /// | | | | | | , , |
| | Sta Registr | _ | | 10V 0 8 2 | 2005 | Les ze | M | Some | 1 | | | | | | | | |

State of Maryland / Department of Health and Mental Hygien 2005 38163 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 9 1:40 p M 2005 Lena Rebecca Willey /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Feb. 12, 1918 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 25%F Yrs. 214-07-9176 87 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location il Hygiene. other than "natural", or itema 23a or 28a-f ahow vent, the Medical Examiner must be multied at Dorchester Linkwood 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3657 Karen Circle 21835 IISA Maryland 21215-0036 $\mathcal{U}\mathcal{D}\mathcal{U}$ Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 8 own home or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Mental it of Health and Menta John Baldwin Fitzhugh Lena Elzey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Levin Willey 5218 Sunflower Lane, Linkwood, MD son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1' Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Church Creek, MD 4 ☐ Donation 5 ☐ Other (Specify) Old Trinity Churchyard 11/11/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Drie k. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebn rescular Accident-**Physician** /Medical Due to (or as a consequence of) Examiner + terroscleror's Heer1-Dicese Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetel death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached o 9 Unknown 9 Unknown Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PNo 3 Probably 4 □Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 2.₽No of Vital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After **Division** 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital 24 hours a pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of coniner 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) CAMPRIDGE MOMAN THANKSY 300 AUROLA 37 Registrar's Signature 31. Date filed (Month, Day, Year) State 2005

DHMH 17 Rev 1/2001

Registrar

| | | | 1 10000 | State of Maryla | | ent of Health and | - | | |
|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------|------------------------------------------|------------------------------------|---------------------------------------|
| | | | 1 - For State Registrar | State of Maryla | | ent of Health and ate of Death | | 0000 0 | 2011.1. |
| | | | Decedent's Name (First, Middle, La | st) | 00/11/10 | ale of Dealif | Reg. N | | 3. Time of Death |
| | Physici /Medio | | Mary 1 | tenry 1 | Noolfo | rd | November D | 5, 2005 | 5 AUM |
| | Examir | | 4a. Facility Name (If not institution, giv | | | City, Town, or Location of Dea | | c. County of Death | |
| | | | | lyenue Ap | t. 202 (| Cambridge | | Dorches | ter |
| П | Funeral Director | | 5. Social Security Number 6. S | iex 7. Age (In yrs | s. last birthday) If U | nder 1 Year If Under 24 Hr ths Days Hours Mir | n. (Month, Day, Yea | 9. Birthplac | e (State or Foreign |
| | | | Usual Residence of Decedent | 70 | | | May 23,1 | 904 Mar | ryland |
| | nylan how | _ | 10a. State 10b. County | 10c. C | city, Town or Location | | | 10d. | Inside City Limits |
| | 88-f | oto | MD Dorc | hester | Cambr | idge | | | 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ |
| | with t | Funeral Director | 10e. Street and Number | n | 1 2 2 2 2 | Zip Cade | 10g. C | itizen of What Country | ? |
| | Jeath The 23 | erai | 202/Neteor | 12. Was Decedent Ever in | pt. 202 | 2/6/3 | Specify Yes or No- | 14. Race - American | Indian |
| 9 | after or iter | Fur | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 D No | | ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue | irto Rican, etc.) | Black, White, etc | |
| 2-0036 | ural', | d by | 3 Widowed 4 □ Divorced | If Yes, Give Year or Dates: | 1 □ Ye | s 202 No Specify: | | Specify: Blac | 1< |
| _ | should be filed within 72 hours after death with the Maryland nd Mental Hygiene. • marked other then "natural", or items 23a or 28e-f ehow umatic event, the Medical Examiner must be notified at | Completed by | 15. Decedent's Education (Specify only highest gradual) | ducation ade completed) | 16a. Decedent's l | f work done during most of w | orking 16b. | Kind of Business/Indus | itry |
| 212 | with!lene. | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) | Hous | T use retired) | | Win Ha | Me_ |
| | e filed Il Hyg other | BeC | 17. Father's Name (First, Middle, Last, | | 17043 | | ame (First, Middle, Maide | | /VIC |
| Maryland | should be filed withir nd Mental Hyglene. marked other then matic event, the M | ToE | Jason | Henry | / | Wilh | emina | Plater | |
| lan. | 0 a a a | | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Mailing Add | ress (Street and Number or F | Rural Route Number, City | or Town, State, Zip Co | ode) |
| | s 1 and of Health item 27 other tr | | Gloria 1 | 1001 Ford | Place of Disposition | ashington | | ridge, Mi | 0,21613 |
| چ | Pages nent of H int: If ite iry or of | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Removal from State | cemetery, crematory | or other place) | , , , , , , , | ocation City or Town | |
| Baltimore, | permit. Pag Department Importent: any injury c | | 4 □ Donation 5 □ Other (Specifical Service Licer) | - 01 | d Field (| emetery // | 111/05 Ch | urch Cre | ek, MD. |
| ä | permit. Departr Imports any nj | | Danolla, | C. 2/0424 | Hen | and Address of Facility RY FUNERO WAShingt | 1 Home, P. | A. A. | n 21612 |
| | | | 23a. P. rt1 Enter the disease, or com | plications that ceused the dea | th. Do not enter the | node of dying, such as andia | ac or respiratory arrest, | U A | proximate |
| | Physician | | Immediate Cause (Final disease or condition | | inco An | teru Diser | 50 | | terval Between |
| | /Medical Examiner | | resulting in death) | Due to (or as a conse | quence of): | 701704 | | 74 | or) |
| | Lxammer | _ | Sequentially list conditions. | b. Due to (or as a conse | | | | | |
| | ned | Examiner | Sequentially list conditions, if any, leading to immediate eause. Enter Uncertying Cause (Disease or Injury | Due to (or as a conse | querice or): | | | | |
| J, | execu n and ial-tra | Exa | that initiated events resulting in death) Last | Due to (or as a conse | quence of): | | | | |
| 3/60 | death certificate be executed e attending physicien and of for use as the burial-transit | icai | | d | | | | | |
| õ | artifica ing ph e as th | Physician/Med | IF FEMALE: | | | | | | |
| X Q Q | eath certific attending pl | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregn 1☐Live birth 2☐Fet | el death 3 □Ectopi | c pregnancy | 7 | 23d. Date of delivery Month Day | y Year |
| j | | ysic | 1 ☐ Yes 2 ☐ Do 9 ☐ Unknown | 4 □ Pregnant at time of 9 □ Unknown | death 5 ☐ Other | (specify) | | | , |
| Ž. | requires that the een signed by th hould be detache | by Ph | Part II. Other significant conditions c | ontributing to death but not re- | sulting in the underlying | ng cause given in Part I. | 23e. Did tobacco | use contribute to the c | ause of death? |
| cords, | w requires that been signed b should be deta | ed b | | | | | 1 ☐ Yes 2 | 3 Probably | / 4 □Unknown |
| ပ္သ | law as b 2 sl | plet | | | | | 24a. Was an | 24b. Were autopsy | findings available |
| ř | The ate h page | Completed | | | | | autopsy performed? 1 ☐ Yes 2 2 200 | death? | etion of cause of |
| VII | Physicien: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | ath (Check only one) | 1157 | |
| ö | hys his | <u>유</u> | 1 Yes 2 No 27. Manner of Death | 1 Linpatient 2L | ER/Outpatient 3 28b. Time of | | Home 5 Pesidence | | |
| 5 | Attending I r death. ector: After by the funer | tion | 1 Statural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | Injury | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe flow inju | ry occurred | |
| VISION | Attendii er death. rector: A by the fu | Iffica | 3 Suicide 6 Could not be determined | | jome, farm, street, fac | | 28f. Location (Street a. | nd Number or Rural Ro | oute Number, |
| 5 | tel or rs afte el Dire ed in b | Certification; | 4 Homeda | building, etc. (Speci | <i>iy)</i> | | City or Town, State | 9) | |
| | To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the | edical | (Check only 2 Medical Exam | ysician: To the best of my kniner: On the basis of examination | owledge, death occurration and/or investigat | ed at the time, date and place | e, and due to the cause(s |) and manner as stated | d. |
| | To the within 2 To the complet | Med | 29b. Signature and title of certifier / | and manner stated. | | 29c. License number | | ite signed (Month, Day | |
| | F 3 F 8 | | Van 1/2 | | | 451900 | 250.00 | 1/8/05 | , |
| | | | 30. Name and iddress of person who | completed cause of death (Ite | m 23a) (Type, Print) _ | 471773 | 7 1 1 | 7 6/05 | |
| | | | Eugene News | iver DO | 503 | Sym St | -ambrid | 15 MO 21 | 613 |
| | Sta Registra | | 31. Date filed (Month Pox Year) 9 | 2005 32. Registrar's Sign. | ature | | | | |
| | negisti | AT . | | " A har dela se" | A.S. A.B. S. | S. J | | | |

| | | | For State | State of Maryla | | artment of H | | | 0000 | 00115 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------|---------------------------------|-----------------------------------|---------------------------|----------------------------------------------------|
| | 6 % | a. | Registrar 1. Decedent's Name (First, Middle, L | ast) | | ranoate or t | | Reg. I | No. UUD | 3. Time of Death |
| | Physici /Medic | | Michael | Anthony | W | hite | N | | Day Year 04 2005 | 4:00 A M |
| 1 | Examin | | 4a. Facility Name (If not institution, ga | ive street and number) | | 4b. City, Town, or | Location of Death | | 4c. County of Dea | |
| | | | Old Ocean City | | | Salisbur | | | Wicomic | |
| | Funeral Director | | | Sex 1 ★ 2 F 7. Age (In yr | rs. iast birthday) Yrs. | If Under 1 Year Months Days | Hours Min. | Date of Birth (Month, Day, Yes | | thplace (State or Foreign ountry) |
| ₹ | 4 | | Usual Residence of Decedent | 32 | | | J | uly 11, | 1973 | Md. |
| | nylan how | _ | 10a. State 10b. County | 10c. | City, Town or L | ocation | | | | 10d. Inside City Limits |
| | 88a-1 | Director | Md. Wicom | ico Sa | alisbu | | | | | 1 XYes 2 No |
| | with t | Dir | 10e. Street and Number 510 Robinso | n st | | 10f. Zip Code 21801 | | 10g. | Citizen of What Co USA | ountry? |
| | death ms 23 | Funeral | 11. Marital Status | 12. Was Decedent Ever in | | Was Decedent of Hi | ispanic Origin? (Specif | y Yes or No- | 14. Race - Ame | |
| 21215-0036 | be filed within 72 hours after death with the Maryland nat Hygiene. Ind other then "natural", or Items 23a or 28a-1 ehow event, the Medical Examiner must be notified at | þ | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | If Yes, specify Cuba 1 ☐ Yes 2 🛣 No | n, Mexican, Puerto Ric | an, etc.) | Specify: | _{te, etc.} Black |
| 2-0 | 72 ho | Completed | 15. Decedent's (Specify only highest of | | (Give | dent's Usual Occupa | during most of working | 16b | . Kind of Business | /Industry |
| 121 | C * M | mpi | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired |) | Da | vid Rei | o Co |
| | filed v Hygie other t | | 17. Father's Name (First, Middle, Las | st) | Dan | uscaping | 18. Mother's Name (F | | | ia co. |
| Maryland | s should be filed within and Mental Hygiene. Is marked other then aumatic event, the Miles | To Be | | | | | | | , | |
| ary | 2 should and Men Is marke sumatic | - | Tyrman W 19a. Informant's Name/Relationship | hite (Type, Print) | 19b. Maili | ng Address (Street a | Evelyn and Number or Rural F | loute Number, Cit | y or Town, State, . | Zip Code) |
| | 1 and 2 Health a tem 27 is | | Evelyn Y. Whi | te / Mother | 510 | Robinso | on st. S | alisbur | y,Md.21 | 801 |
| Baltimore, | o to | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 | ☐Removal from State | cemetery, cre | osition (Name of matory or other plac | | | Location - City or | |
| Ë | permit. Pages Department of Important: If if any Injury or c | | 4 ☐Donation 5 ☐ Other (Spec | | | Hill Mem | | | lebron,M | |
| Bal | permit. Pag Department Important: I any Injury o | | 21. Signature of Funeral Service Lic | la Krind | 1 9 | 17 W. Is | sabella s | t. Sali | | |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that caused the de ly one cause on each line. | eath. Do not en | ter the mode of dying | g, such as cardiac or r | espiratory arrest, | | Approximate Interval Between Onset and Death |
| 1 | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. Mult | | unjurie | 0 | | | Oliser and Death |
| + 3. | /Medical Examiner | | rosaling in dodiny | Due to (or as a cons | equence of): |) | | | | |
| | d sag | er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a cons | equence of): | | | | | |
| | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | |
| oʻ | tate be executed by sicien and the burial-transit | Exa | resulting in death) Last | Due to (or as a cons | equence of): | | | | | |
| 8760, | ate be hysici the bu | dicai | , | d | | | | | | |
| 9 | | 0 | IF FEMALE: | 230 If was outcome of pro- | an an au | | | | | |
| O. Box | The law requires that the death certific ate hes been signed by the attending p page 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of prei 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown | etal death 3[| ⊒Ectopic pregnancy ⊒ Other (<i>specify</i>) | | | 23d. Date of de Month | livery Day Year |
| , P.O. | that the by detail | | Part II. Other significent conditions | contributing to death but not i | resulting in the u | underlying cause give | en in Part I. | 23e. Did tobaco | co use contribute to | o the cause of death? |
| rds | quires n sigr uld be | ed by | | | | | | 1 ☐ Yes | 2 No 3 P | robably 4 Unknown |
| Records, | law require ss been si 2 should t | Completed | | | | | | 24a. Was an | 24b. Were at | utopsy findings available completion of cause of |
| Ä | icien: The lav certificate hes rector, page 2 | E | | | | | | autopsy performed 1 X Yes 2 | ? death? | completion of cause of |
| /ita | cien: ertifica | Be | 25. Was case referred to medical examiner? | | | | 26. Place of Death (0 | | | |
| J o | Physicien: r this certific ral director, | 2 | 1 X Yes 2 No | | ☐ ER/Outpatie | | 4 🗆 Hadising Hollie | | | ocify) Scene |
| Division of Vital | ding I h. After funer | Certification: | 27. Manner of Death 1 □ Natural 5 □ Pending 2 № Accident investigat | 28a. Date of Injury (Month, Day Year, | 12 25 | Worl | Yes 2 No | d. Describe how in | | chile struck |
| isi | Attan deat octor: yy the | fica | 3 ☐ Suicide 6 ☐ Could not | be 28e. Place of Injury - A | t home, farm, st | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | a ti | Ked abil | ural Route Number, an city Rd C |
| Β̈́ | s after | Serti | 4 Homicide | building, etc. (Spe | Roo | Ld | Lo | City or Town, St | salisbur | an city Rd @ |
| | To the Hospitel or Attanding Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page | Medicai (| 29a. Certifier 1☐ Certifying I (Check only one) 1☐ Medical Ex | Physicien: To the best of my is aminer: On the basis of exam and manner stated. | knowledge, dea | th occurred at the tim | ne, date and place, and | due to the cause | e(s) and manner as | s stated. |
| | To ti withi To ti comp | M | 29b. Signature and title of certifier | mis | | 29c. License | e number | | Date signed (Mont | |
| | | | 30. Name and address of person wh | _ | tem 23a) (Type | | | | | |
| | - W. F | | LING LI | , Mr. D | anaturo. | 111 Pe | enn Street | Baltimo | ore, Mary | 1and 21201 |
| | Sta Regist | | 31. Date filed (Month, Day, Year) | 2005 32. Hamistrar's Sig | griature M | Angel. | | | | |
| DI | MH 17 Pey 1/2 | - | | JAMES OF STREET | No A | THE CALL | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

| | 1 - For State Registrar | State of Marylar | | ate of Death | Reg. | 611115 | 38141 |
|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------|
| | Decedent's Name (First, Middle, Last | 1) | | | 2. Date of Death | | 3. Time of Death |
| nysician | William Thoma | as Ward | Sr. | | Month | Day. Year | 0420 |
| dical niner | 4a. Facility Name (If not institution, give | | | ity, Town, or Location of Dea | | 4c. County of Deat | |
| ············ | PENINSULA REGIONOS | | Perter | SALISBUI | 1 | Wicom | 160 |
| eral | 5. Social Security Number 6. Se | | | der 1 Year If Under 24 Hf | | 9. B <u>i</u> rtl | nplace (State or Fore |
| tor | 213-14-1666 Usual Residence of Decedent | ØM 2□F 90 | Yrs. Month | ns Days Hours Mir | 3/7/1915 | Mass | achusetts |
| 4 | 10a. State 10b. County | 10c. Ci | ty, Town or Location | | | | 10d. Inside City Lin |
| any injury or other treumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | Maryland Wicomio | co Sa | lisbury | | | | 1 ☐ Yes 2 万 |
| Funeral Director | 10e. Street and Number | | 10f. | Zip Code | 10g. | Citizen of What Co | untry? |
| | 1008 Riverhouse I | Dr., Apt. 5 | | 21801 | | USA | |
| ner | 11. Marital Status | 12. Was Decedent Ever in U | .S. 13. Was De | cedent of Hispanic Origin? (| Specify Yes or No- | 14. Race - Ame | |
| 2 | 1 Never Married 2 Married | 1 ⊒ Nves 2 ⊟ No | | | nto Hican, etc.) | Black, White | |
| þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: Ar | my Tures | s 2 No Specify: | | Specify: Wh: | LLE |
| ted | 15. Decedent's Edi (Specify only highest grad | ucation | 16a. Decedent's U | Isual Occupation | 166 | b. Kind of Business/ | Industry |
| pie | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NO | work done during most of w T use retired) | orking | | |
| Completed | 12 | - | Refrigera | ation Enginee | r (| Campbell S | Soup Co. |
| Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Na | ame (First, Middle, Mai | den Sumame) | |
| To B | George William V | Vard | | Esther | Crowley | | |
| 9 | 19a. Informant's Name/Relationship (T. Martha Ward Mulfor | | | ess (Street and Number or F Dagsboro Rd., | | | Tip Code) |
| | 20a. Method of Disposition | 20b. I | Place of Disposition (i | Name of | Date 200 | . Location - City or | Town State |
| | 1 ☐ Burial 2 ☐ Cremation 3 ☐ I | | Place of Disposition (incometery, crematory of | | | • | |
| ì | 4 □ Donation 5 □ Other (Specify, | | isbury Cre | | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | Salisbury | |
| once. | 21 Signature of Funeral Service Licens | | 名 | and Address of Facility Oway Funeral Snow Hill Rd. | Home Profe , Salisbur | ssional A y, MD 218 | ssociatio |
| | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | lications that caused the dear | th. Do not enter the n | node of dying, such as cardi | ac or respiratory arrest, | | Approximate Interval Between |
| an | Immediate Cause (Final disease or condition | Acuto Pa | nal Fach | | | | Onset and Death |
| al | resulting in death) | a. Flour No. | | we | | | 3 days |
| ier | | Aritte bu | band Mus | led aughter | led Tiller | Taca | 3 Rock |
| ē E | Sequentially list conditions, if any, leading to immediate | Due to (or as a consec | quence of): | hat ougolara | na cigaro | enn | 7 |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | CORDINA | astores | Dun! | • | | HD+UN |
| ical Examin | resulting in death) Last | Due to (or as a consec | pence of): | 20.000 | | | 1-11 |
| call | | d | | | | | |
| edic | | d | | | | | |
| N/ | IF FEMALE: | 23c. If yes, outcome of pregn. | ancy | | | 22d Date of dali | |
| clan/Medi | in the past 12 months? | 1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c | al death 3 ⊟Ectopia | c pregnancy | | 23d. Date of deli Month | very Day Year |
| y Physician/M | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9 Unknown | JUNIER SUDVINER | spoony/ | | | |
| | Part II. Other significant conditions co | ontobuting to death but not res | sulting in the underlyin | ra cause gwen in Part I | 23e Did tobac | co use contribute to | the eause of death? |
| | Dyperteurius | | and an area areas in a second | g oddso givori ii i ait i. | | | bably 4 Unkno |
| Completed | The second of | 7 | 2 | ., ., ., . | 1 165 | 20540 30 FR | ———————— |
| o Be Comple | CARENHOURA | OF The PR | VHUL | | 24a. Was an autopsy | 24b. Were au | topsy findings availation |
| E OS | | | | | performed | d? death? | 2 □ No |
| e e | 25. Was case referred to medical | | | 26. Place of De | eath (Check only one) | | |
| To Be C | examiner? | Hospital: 1 Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing | Home 5 Residence | e 6 □Other (Spec | ufv) |
| 2 5- | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of | 28c. Injury at Work? | 28d. Describe how i | | , |
| ation | 1. Natural 5 ☐ Pending 2 ☐ Accident investigation | | Injury M | 1 ☐ Yes 2 ☐ No | | | |
| 100 | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | ome, farm, street, fac ly) | tory, office | 28f. Location (Stree City or Town, S | t and Number or Ru tate) | ral Route Number, |
| ertific | | | owledge death occur | red at the time, date and place | ce, and due to the caus | e(s) and manner as | stated. |
| ely filled in by the funera ical Certification; | 29a. Certifier 1 Certifying Ph | ysicien: To the best of my knowing. On the basis of examinations. | ation and/or investigat | tion, in my opinion, death occ | curred at the time, date | | to the cause(s) |
| Aedical Certific | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone) | ysicien: To the best of my kniner: On the basis of examination and manner stated. | ation and/or investigat | tion, in my opinion, death occ | | | to the cause(s) |
| Medical Certific | 29a. Certifier 1 Certifying Ph | iner: On the basis of examina | ation and/or investigat | 29c. License number | 29d. | Date signed (Month | to the cause(s) |
| Medical Certific | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone) | iner: On the basis of examina | ation and/or investigat | tion, in my opinion, death occ | 29d. | | to the cause(s) |
| | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone) | and manner stated. Suldauli completed cause of death (Iter | ation and/or investigat | 29c. License number | 29d. | Date signed (Month | to the cause(s) |

DHMH 17 Rev 1/2001

213-14-1666

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 16 20051245pm /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security lumber 7 Ht If Under 1 Year Birthplace (Sate or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□ M 2XXX 79 Yrs. Director 227-28-8106 JAN.24,1927 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits i is marked other than "neturel", or items 23a or 28a-f show traumatic event, the Medical Examiner mast be notified at MARYLAND ST. MARY'S 1 ☐ Yes 2 ☒ No Director LEXINGTON PARK 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21412 GREAT MILLS ROAD 20653 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 DIETITIAN SALEM CO. HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EUGENE NEWTON BURROUGHS SALLY REEDY ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 is BRENDA VACCARO-DAUGHTER 6214 DOUGLAS CIRCLE, WALDORF, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If Itel any Injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITIAN CREMATORY 11-18-05 ALEXANDRIA, VA M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disaase or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner sician and buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical attending physic d for use as the b Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be detached 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Linknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes 1 ☐ Yes 2 TONO 1 Yes 2 No funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 → Mursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 XX this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation after death.

I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a
To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person ed cause of death (Item 23a) (Type, Print) Great Mills Rd. 40/14wood, MD 20636 James 31. Date filed (Month, Day, Year) State

Registrar

Keith A. Young 05-7576 AKG

| 7770 | | | State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department of Health / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / D | Mental Hygie | 2005 | 38148 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------|-----------------------------------------------|
| | * | | Decedent's Name (First, Middle, Last) | 2. Date of Death | Day Year | 3. Time of Death |
| | Physicia /Medic | | Keith Alan Young | November | | 12:11 A M |
| 2 | Examin | | 4a. Facility Name (If not institution, give street and number) 4b. City/Town, or Location of Death | | 4c. County of Death | |
| 7 | \$ 100 m | | Easton Memorial Hospital Faston 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Talbot | place (State or Foreign |
| 9 | Funeral Director | | 212-86-0560 12M 2 F 7. Age (III 71s. last birthday) Months Days Hours Min. | (Month, Day, Ye | | place (State or Foreign ntry) |
| 9 | D | | Usual Residence of Decedent | 00000 | 700 7710 | |
| | how thow | _ | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits 1 1 Yes 2 No |
| \sim | 8a-f s | ecto | MD talbot Easton 10e. Street and Number 10f. Zip Code | 100 | . Citizen of What Cou | |
| R | with the a or 2 | D. | 2:2 21 | log. | $11 \subset \Delta$ | intry : |
| ζ_{ν} | ns 23 | Funerai Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14. Race - Amer | |
| 9 | or Her | Fur | Armed Forces? Armed Forces? I Pes, specify Cuban, Mexican, Puerto I Pes, Give I Yes, Specify Cuban, Mexican, Puerto I Yes, Sive I Pes 2 No Specify: | o Hican, etc.) | Black, White | , etc. |
| 5-0036 | within 72 hours after death with the Maryland ene than "natural", or items 23a or 28a-f show than "kedical Examinar must be notified at | d by | 3 Widowed 4 Divorced Year or Dates: | | 810 | rck |
| 5- | "natu | Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of won life. DO NOT use retired) | king 161 | b. Kind of Business/li | ndustry |
| 2121 | within ene. than | duic | Elementary/Secondary (0.12) College (1.40r5+) Food Preparation Wa | rker K | Restaura | ant |
| Ď | il Hygid other | BeC | | ne (First, Middle, Mai | | |
| /ar | uld be Vienta Irked Itic ev | ToB | Raymond Young Luci | 11e W | 1150n | |
| Maryland | 2 sho and l | | 19a. Informant's Name/Relationship (Type, Priht) 19b. Mailing Address (Street and Number or Ru | ral Route Number, C | Cify or Town, State, Zi | D. 21601 |
| 6, | 1 and 4ealth am 27 ther to | | Lucille Wilson 313 Cherry St. Ap 20a. Method of Disposition 20b. Place of Disposition (Name of | Till <u>Fa</u> . Date 200 | S TON (VI | <u> </u> |
| nor | ages nt of h t: if its | | 1 Burial 2 Cremation 3 Removal from State | 16/05 Ti | 2000 M | mouland |
| 3altimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or titems 23a or 28a-f show appring to other traumatic event, the Medical Examination at an ance. | | 22 Name and Address of English | | rappe, Mo | 14910110 |
| Ba | Depa Impo any ir | | Janelle C. Henry Funeral I Siowashington | St. Cam | bridge, M | D.21613 |
| ~3° | | | 23a. Part/ Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. | or respiratory arrest | , 3) | Interval Between |
| | Physician | | Immediate Cause (Final disease or condition Cardiac Arrhythmia | | | Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | |
| ats. | | 70 | Sequentially list conditions, If any leading to any mentions, Use to (or as a consequence of): | | | |
| | uted I Insit | Examiner | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events C. | | | |
| oʻ | be executed ician and burial-transi | | resulting in death) Last Due to (or as a consequence of): | | | |
| 3760, | e ys | ical | d | | | |
| 99 x | 9 40 | Physician/Med | IF FEMALE: 23c. If yes, outcome of pregnancy | | 204 0 4 4 4 5 | · |
| Вох | attending for use as | ian | 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? | | 23d. Date of deliment | Day Year |
| P.O. | that the de ed by the detached | ysic | 1 Yes 2 No 9 Unknown | | | |
| | res that igned b be deta | by Pt | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobac | cco use contribute to | the cause of death? |
| rds | v require been sig should b | | | 1 ☐ Yes | 2 No 3 Pro | obably 4 Unknown |
| ဝင္ | law re es be | Completed | | 24a. Was an autopsy | 24b. Were au | opsy findings available ompletion of cause of |
| <u> </u> | : The l | Соп | | performe 17⊠Yes 2□ | d? death? | 2 No |
| Vita | ysician: T is certificat director, pa | Be | examiner? | ath (Check only one) | 0.5700 (0. | |
| ō | g Phys ler this neral di | . To | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at | lome 5 Residence 28d. Describe how | | ity) |
| ion | nding lath. r: After e funer | atlor | 1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No | | | |
| Division of Vital Records, | al or Attendi after death. I Director: A d in by the fu | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Stree City or Town, | et and Number or Ru State) | ral Route Number, |
| | To the Hospital or / within 24 hours after To the Funeral Direction completely filled in b | | | diagonomens w | . 315 (1) (1) (1) (1) (1) (1) | |
| | Hosp 24 hou Fune fely fi | Medical | 23a. Cather (Check only one) Contifying Physician To the best of my knowledge death continued at the time date and place XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur | | | |
| | o the o the omple | Med | 29b. Signature and title of centier 29c. License number | 29d | I. Date signed (Month | i, Day, Year) |
| | ⊢ ≰ ⊨ ō | | O.C.M.E. | Nov | vember 10, | 2005 |
| | | | 30. Name and address of person who completed cruse of death (Item 23a) (Type, Print) | | | |
| | | | S, Z. HOGAW 111 Penn Street, 31. Date filed (Month, Day Year) 15 20032. Registar's Signature | Baltimore, | , Maryland | 21201 |
| | | ate | 31. Date filed (Month, Day, Year) | | | |

| | | 1 | FOR | partment of Health and It ertificate of Death | Mental Hygie | 2000 | 38149 |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------|-------------------------------------------------|
| | | _ | Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | Physicia /Medic | | John R. Anderson | | November | 27 2005 | 2:00 PM |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 1 | 4c. County of Death | _ |
| | | | 8247 Silver Run Court | Pasadena V) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Anne Aru | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda | Months Days Hours Min. | (Month, Day, Ye | 9. Birth 10/15 | iplace (State or Foreign intry) |
| | Director | | 217-42-3105 G0 Yrs Usual Residence of Decedent | | 000. 24 | 1343 | |
| | ylanc how | . [| 10a. State 10b. County 10c. City, Town or | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No |
| | e Mai | cto | Maryland Anne Arundel | Pasadena | | | |
| | ith th | Director | 10e. Street and Number | 10f. Zip Code | 10g. | Citizen of What Cou USA | untry? |
| | s 23a | ia. | 8247 Silver Run Court 11 Marital Status 12. Was Decedent Ever in U.S. 1 | 21122 3. Was Decement of Hispanic Origin? (S | pacify Yas or No- | 14. Race - Amer | ican Indian, |
| 10 | Iter de | F | 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No | 3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert | o Rican, etc.) | Black, White | |
| 93 | 72 hours after death with the Maryland Insturel; or Items 23a or 28a-f show Jical Exactinet must be notified at | Completed by Funeral | 3 ☐ Widowed 4 反 Divorced If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | | Specify: Wh | rte |
| 2-0 | 72 hc | etec | (Specify only highest grade completed) (G | cedent's Usual Occupation ve kind of work done during most of wor DO NOT use retired) | | b. Kind of Business/l | ndustry |
| 121 | e filed within al Hygiene. I other than " | mp | Elementary/Secondary (0-12) College (1-4or 5+) | Owner - | | General S | tore |
| N D | filed v Hygie Sther 1 | ပ္ပို | 12 4 | | ne (First, Middle, Mai | | 001 0 |
| an | 0 = 0 | To Be | Raymond J. Anderson | Anne | Kurz | | |
| ary | 2 should and Men Is marke aumatic | | | ailing Address (Street and Number or Ru | | | ip Code) |
| Σ | and 2 salth a n 27 Is | | Nobe finder sent (Con) | 52 Kings Road, Pas | | | - |
| Baltimore, Maryland 21215-0036 | of He | | 1 Rurial 2 VCremation 3 Removal from State | position (Name of rematory or other place) | . 02 | c. Location - City or 1 | |
| ţ. | i. Pag tmeni tant: tant: | ١, | '4 □Donation 5 □Other (Specify) Metro C | rematory Inc 2 | 000 | ltimore, | |
| Bal | permit. Pages 1 and Department of Healti Important: If item 2: any injury or other tonce. | | 21. Signature of Funeral Service Lipensee | 3111 Mountain Ro | | | Home, P.A. |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not shook, or heart failure. List only one cause on each line. | | | | Approximate Interval Between |
| | Pnysician : | | Immediate Cause (Final disease or condition | | IS EASE | | Opert and Death |
| | /Medical | | resulting in death) a. Due to (or as a consequence of): | | | | |
| Ы | Examiner | | Sequentially list conditions, b. Due to (or as a consequence of): | | | | |
| _ | ed sit | nine | Sequentially list conditions, if any, leading to immediate ause. It is a consequence of the cause (Disease or injury) | | | | |
| | and and al-trar | Examine | that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | |
| 8760, | The law requires that the death certificate be executed the second signed by the attending physician and the best should be detached for use as the burial-transit orge? | | d | | | | |
| 9 | rtifica ng ph as th | Physician/Medical | IF FEMALE: | | | 1 | - LV = |
| Вох | leath certific attending pl | lan/I | 23b. Was decedent pregnant in the past 12 months? | 3 Ectopic pregnancy | | 23d. Date of deli Month | very Day Year |
| | the a | ysic | 1 Yes 2 No 9 Unknown | 5 Other (specify) | | | |
| P.0 | s that the de ned by the a detached t | | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobac | cco use contribute to | the cause of death? |
| rds | quires n sign | d by | TOBACCO | | 15 Yes | 2 No 3 Pr | obably 4 Unknown |
| Records, | aw require is been sig 2 should b | Completed | | | 24a. Was an autopsy | 24b. Were au | topsy findings available completion of cause of |
| R | The la ate ha page 2 | mo | | | performe | | |
| Vital | i cien: Th certificate rector, pag | Be C | 25. Was case referred to medical examiner? | | ath (Check only one) | - | |
| of V | Physicien: this certificated free director, I | 2 | 1 ☐ Yes 275 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa | | Home 5 Residence | | cify) |
| | Jing P | lon: | 27. Manner of Death 1 | | 28d. Describe now | injury occurred | |
| Division | eatleatlor: | ficat | 3 Suicide 6 Could not be | | | et and Number or Ru | ıral Route Number, |
| Ď | Sir the | Certification: | 4 Homicide building, etc. (Specify) | | City or Town, | State) | |
| | To the Hospital or Att within 24 hours after of To the Funerel Direct completely filled in by | | 29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch | eath occurred at the time, date and plac | e, and due to the caus | se(s) and manner as and place, and due | stated. to the cause(s) |
| | ths H hin 24 the F nplete | Medical | one) and manner stated. 29b. Signature and title of certifier | 29c. License number | | I. Date signed (Monta | |
| | V W I O O | _ | 29. Signature and this of continuous | _ | , | 1/28/05 | |
| 7 | Phi | | 30. Name and address of person who completed cause of death (Item 23a) (T) | pe, Print) | | • | |
| | 1541 | | DABBS, WM A. | Day 768 ARNOLD M | D 21 | 210 | |
| | | ate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | Societé) | | | |
| | Regist | rar | NOV 2 9 2005 Mayor & | Name of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last o | | | |

| | | | 1 - For State Registrar | State of Mary | land / Depa | | lealth and | Mental Hyg | | 38150 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------|--------------------------------------------------------------|---------------------|-----------------------------------|-------------------------------------|------------------------------------------------------|
| | Dhuciai | an | Decedent's Name (First, Middle, Last, | | | | | 2. Date of Dear Month | th Day Year | 3. Time of Death |
| | Physici /Medic | | DeLellis Shramek | | _ | 41 Oh Tour | a Lagation of Deat | 11 | 22 200 4c. County of De | |
| | Examin | er | 4a. Facility Name (If not institution, give 3412 Chiswick Ct | street and number) | | Silver S | r Location of Deat | rı | Montgome | |
| | Funeral | | 5. Social Security Number 6. Sec | | yrs. last birthday) | If Under 1 Year Months Days | | | Year) 9. Bi | inthplace (State or Foreign |
| | Director | | 220 01 1309 | ™ 2√F 96 | Yrs. | Months Days | TIOUIS WIII. | 10-13-1 | | oraska |
| | land w | | Usual Residence of Decedent 10a. State 10b. County | 100 | c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | Mary | tor | MD Montgome | ry S | ilver Sp | ring | | | | Yes 2 □ No |
| | ith the | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What 0 | Country? |
| | s 23a | | 3412 Chiswick Ct | 12. Was Decedent Ever | in 11 6 12 | 20906 | lineania Origina (6 | | USA 14. Race · An | aprican Indian |
| 10 | ter de | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give | | Was Decedent of Hit Yes, specify Cub | an, Mexican, Puer | to Rican, etc.) | Black, Wh | ite, etc. |
| 036 | ral', or | b | 3 Widowed 4 □ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☐ No | Specify: | | Specify: wh | nite |
| 5-0 | s within 72 hours after death with the Maryland liene. r than "natural", or itams 23a or 28a-f show the Medical Evantiner must be inclifted at | Completed | 15. Decedent's Edu (Specify only highest grad | cation e completed) | (Give | dent's Usual Occup kind of work done DO NOT use retire | during most of wo | rking | 16b. Kind of Busines | s/Industry |
| Maryland 21215-0036 | filed within Hygiene. other than rant, the Me | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) | House | | ۵) | | At home | |
| d 2 | Hys at the | Be C | 17. Father's Name (First, Middle, Last) | | 110050 | WIII C | 18. Mother's Na | me (First, Middle, i | | |
| ylar | should be and Mental s markad c umatic ava | To | Joseph Shramek | | | | | sparek Si | | |
| Mar | and and sum | | 19a. Informant's Name/Relationship (7) Andrew J. Adams J. | | | | | | ; City or Town, State, rlington, | |
| | 1 an Heal am 2 thar | | 20a. Method of Disposition | | | osition (Name of matory or other pla | | | 20c. Location · City of | |
| OE I | e = 5 | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify) | temoval num State | | | ! | 8-2005 | Beltsvillo | - MD |
| Baltimore, | e in tra | | 21. Signature of Funeral Service Licens | | 2: | Name and Addre | ss of Facility | | | |
| 8 | Dep Imp | | | | | | | | | 3 Gist Ave. |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final | _ | | ter the mode of dyll | ng, such as cardia | c or respiratory arr | est, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | Due to (or as a co | | | | | | 7 days |
| | Examiner | | Conventially list conditions | Epileption | | <u>.</u> | | | | |
| | po iis | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a so | и веционов оту: | | | | | |
| | xecute and | Examiner | that initiated events resulting in death) Last | c. Due to (or as a co | ensequence of): | | | | | |
| 760, | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit | calE | | d | | | | | | |
| 68 | rtificat ng phy as th | | IE ECNAL C. | | | | | | | |
| Вох | ath cei ttendii or use | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of p | Fetal death 3 | ⊒Ectopic pregnanc | у | | 23d. Date of d Month | elivery Day Year |
| 0. | that the dealed by the a | ysic | 1 ☐ Yes 2 MNo 9 ☐ Unknown | 4□Pregnant at time 9□Unknown | e of death 5L | Other (specify) | | | | |
| Δ. | es that tigned by | by Ph | Part II, Other significant conditions co | ntributing to death but no | ot resulting in the u | inderlying cause giv | ven in Part I. | 23e. Did to | bacco use contribute | to the cause of death? |
| Records, | w require been sig should b | ed b | | | | | | 1 □ Y | es 2□No 3□I | Probably 4 KUnknown |
| ecc | has be ge 2 sho | Completed | | | | | | 24a. Was a autops | sy prior to | autopsy findings available completion of cause of |
| al R | | | | | | <u>-</u> | | | 2 □ No 1 □ Ye | |
| Vital | Physician: Th this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | 2 ER/Outpatie | nt 3 DOA Ott | 200 | ath (Check only or | ence 6 ⊡Other <i>(Sp</i> | necify) |
| of | g Phys er this ieral di | n: To | 27. Manner of Death | 28a. Date of Injury (Month, Day Ye | 28b, Time o | | | - | ow injury occurred | ocity) |
| sion | Attanding Ph r death. ector: After th by the funeral | atlo | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | (monat, bay 70 | an, mjory | | Yes 2 □No | | | |
| Division | + 0 D - | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - building, etc. (S | - At home, farm, st Specify) | reet, factory, office | | 28f. Location (S. City or Town | treet and Number or i n, State) | Rural Route Number, |
| | To tha Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by | edical Ce | (Check only 2 Medical Exam | rsician: To the best of miner: On the basis of exa | amination and/or in | | | | | |
| | To tha within 2 To tha complet | Med | 29b. Signature and title of certifier | and manner stated | · / | 29c. Licens | se number | 2 | 9d. Date signed (Mod | nth, Day, Year) |
|) | - s + ō | | Burn | ampas | 1 | D0041 | 072 | 1 | 1-25-2005 | |
| | 6, | | 30. Name and address of person who o | ompleted cause of death | n (Item 23a) (Type | Print) | | 3.5 | - | |
| | 1. | | Mahammed Manipady 31. Date filed (Month, Day, Year) | 10810 Conne | | Ave., Ken | sington, | MD 20895 | 5 | |
| | St Regist | ate rar | NOV 2 9 200 | 11 | H Soc | de | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 _ For

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if Item 27 is marked other then "natural", or Items 23a or 28s-f show any injury or other traumatic event, the Medical Examinational be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

| Registrar | Certificate of Death | Reg. No. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------|
| Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
| George Atken | e IR. | Month Day 25, 205 | - 1:00 M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | |
| 43 39 Reisterstown | , Kai Baltem | ue NA |) |
| 5. Social Security Number 6. Sex 7. Age (In) | (rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 9. Birtl | hplace (State or Foreign untry) |
| DID-20-8701 / | Yrs. | March 23, 1932 m | aryland |
| Usual Residence of Decedent 10a. State 10b. County 10c | City, Town or Location | • | 10d. Inside City Limits |
| 1 | Balting | | 1⊠Yes 2 □ No |
| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Co | untar? |
| 4339 Reisterstown | Pd. 101. Zip code | / [C Z | 1_ |
| 11. Marital Status 12. Was Decedent Ever | n U.S. 13. Was Decedent of Hispanic Origin? (Sp. | pecify Yes or No- 14. Race - Ame | rican Indian |
| 11. Marital Status 12. Was Decedent Ever Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Ves 2 □ No | If Yes, specify Cuban, Mexican, Puerto | Rican, etc.) Black, White | |
| 1 Never Married 2 Married 1 Ses 2 No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☐ No Specify: | Specify: | Black |
| 15. Decedent's Education | 16a. Decedent's Usual Occupation | 16b. Kind of Business/ | Industry |
| (Specify only highest grade completed) | (Give kind of work done during most of work life. ,DO NOT use retired) | steel steel | |
| Elementary/Secondary (0-12) College (1-4or 5+) | Steek worker | - Indu | stry |
| 17. Father's Name (First, Middle, Last) | 18. Mother's Narr | e (First, Middle, Maiden Surname) | 0 |
| Storge Atkens | JR. Louis | a Atking) | |
| 19a. Informant's Name/Re onship (Type, Print) | 19b. Mailing Address (Street and Number or Rui | | Zip Code) |
| Wanda D. Atkins - daughte | | Back md. 2 | 1214 |
| 20a. Method of Disposition | b. Place of Disposition (Name of | Date 20c. Location - City or | Town, State |
| | cometery, crematory or other place) | 2-05 bw. of m | de mo. |
| 21. Signature of uneral Service Licenses | | | |
| 21. Signature of unional policy and a second | 22. Name and Address of Facility | editicion tasa | 7 = |
| 23a. Path. priler the disease, or complications that caused the | Gary financh Fine | | Approximate |
| shock, or heart failure. List only one cause on each line. | 0 | or respiratory arrest, | Interval Between |
| Immediate Cause (Finaf disease or condition | ing Cancer | | 22 mont |
| resulting in death) Due to (or as a cor | | | |
| Sequentially fist conditions, if any, leading to immediate b. Due to (or as a cor | | | |
| if any, feading to immediate Due to (or as a corcause. Enter Underlying | sequence ot): | | |
| that initiated events resulting in death) Last | | | |
| Due to (or as a cor | sequence or): | | |
| if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Due to (or as a cor d | | | |
| F FEMALE: | | | |
| 23b. Was decedent pregnant in the past 12 months? | Fetal death 3 Ectopic pregnancy | 23d. Date of del | ivery Day Year |
| 1 □ Yes 2 □ No 4 □ Pregnant at time 9 □ Unknown 9 □ Unknown | of death 5 Other (specify) | | |
| | | OZa Did tabassa usa santih ta ta | the serves of death? |
| Part II. Other significant conditions contributing to death but not | A Community underlying cause given in Part I. | 23e. Did tobacco use contribute to | |
| Company My Man of 1 | 1 caam | 1 Yes 2 No 3 Pr | obably 4 Unknown |
| 2. | | 24a. Was an 24b. Were au autopsy prior to c | topsy findings available completion of cause of |
| | | performed? death? | 3.4 |
| 25. Was case referred to medical examiner? | 26. Place of Dea | th (Check only one) | |
| 1 ☐ Yes 2 No Hospital: | 2 ER/Outpatient 3 DOA Other: 4 Nursing H | ome 5 Residence 6 Other (Spec | cify) |
| 27. Manner of Death 28a. Date of Injury Month, Day Yes | 28b. Time of 28c. fnjury at Work? | 28d. Describe how injury occurred | |
| 2 Accident investigation | M 1 ☐ Yes 2 ☐ No | | |
| 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S) | At home, farm, street, factory, office | 28f. Location (Street and Number or Ru City or Town, State) | ural Route Number, |
| 2 | J. J. J. J. J. J. J. J. J. J. J. J. J. J | 0.1, 0.1, 0.2.0, | |
| 29a. Certifier Certifying Physicien: To the best of my | knowledge, death consumed at the time, date and plane | and due to the cause(s) and trainier as | stated |
| (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. | mination and/or investigation, in my opinion, death occu | rred at the time, date and place, and due | to the cause(s) |
| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Monta | h, Day, Year) |
| I I Was A Well M | D D D D D D D G 49 | 11 11-28- | -05 |
| 30. Name and address of person who completed cause of death | (Item 23a) (Type, Print) | 11 11-28- LENE AVE-BALTIM | |
| MODRING HERE | 1 - 2401 W. BEVEN | ENE HIE - MALKINI | ME MN 2171 |
| 31. Date filed (Month, Day, Year) 32. Registrar's S | ignature | DIO MOE. DIVINO | |

State Registrar

NOV 2 9 2005

32. Registrar's Signature

| | | | For State Registrar | State of Maryla | nd / Depa | artment of H rtificate of L | ealth a Death | | | Reg. No. | 005 | 38152 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------|--------------------------------------------|------------------|-------------------|----------------------------------------|----------------|------------------------|----------------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle, Last, | | | | | 2 | 2. Date of De. Month | Day | Year | 3. Time of Death /2:25 p M |
| 13 | /Medic | al | Joan Rachel 4a. Facility Name (If not institution, give | Appel | | 4b. City, Town, or | Location of | f Death | | 23 4c. c | G5 county of Death | |
| | Examin | er | Union Memorial Hos | _ | | Baltimo | | , | | | | |
| | Funeral | | 5. Social Security Number 6. Set | | | If Under 1 Year Months Days | If Under 2 | 24 Hrs. 8 | B. Date of Bird (Month, Date 10/1/1 | th y, Year) | 9. Birtt | nplace (State or Foreign untry) |
| | Director | | 212–34–9974 | 69_ | Yrs. | montro Dayo | | 1 | 10/1/1 | 936 | | ylánd |
| | ow ow | | 10a. State 10b. County | 10c. C | ity, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| | Many Many | tor | Maryland Baltimor | e Mio | ddle Ri | ver | | | | | | 1 ☐ Yes 2X No |
| | or 28 | Funeral Director | 10e. Street and Number | | | 10f. Zip Code | | | | 10g. Citize | en of What Co | untry? |
| | 23a | rai | 430 Carroll Island | | 11.0 | 21220 | | -:-2/0: | | U. S | . A. I. Race - Amer | icen Indian |
| | Item de | -une | 11. Marital Status 1 □ Never Married 2 Married | 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 X No | 1 | Was Decedent of Hi If Yes, specify Cuba | n, Mexican | , Puerto Ri | ican, etc.) | . ' | Black, White | |
| 920 | al', or | þ | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 □ Yes 2 ŪMNo | Specify: | | | 5 | Specify: Wi | nite |
| 21215-0036 | within 72 hours after death with the Maryland ane. than 'natural', or lieme 23a or 28a-f ehow he Mauleal Examinar charitie indiffed at | Completed | 15. Decedent's Edu (Specify only highest grad | cation completed) | (Give | dent's Usual Occupa | during most | of working | 7 | 16b. Kind | d of Business/I | ndustry |
| 121 | within ane. then | dm | Elementary/Secondary (0-12) | College (1-4or 5+) | Homen | DO NOT use retired, |) | | | Oran | Homo | |
| d 2 | Hygie Hygie Sther ent, | | 12 17. Father's Name (First, Middle, Last) | | Попел | aker | 18. Mothe | r's Name (| First, Middle. | | Home | |
| lan | Hental Hental rked c | To Be | Clarence Gravson | Baxter | | | Jose | ephine | e Bau | cia | | |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liteme 23a or 28a-1 ehow appriantry or other treumatic event, the Madical Examiner class the nutified at once. | 10 | 19a. Informant's Name/Relationship (T) | pe, Print) | 19b. Maili | ng Address (Street a | and Numbe | r or Rural i | Route Numbe | er, City or | Town, State, 2 | ^(ip Code) 21220 |
| ≥, | and sealth m 27 | | Ernest Valentine A | | | Carroll I | sland | Road | | | iver, I | Maryland |
| Baltimore, | ages 1 nt of H : If ite | | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F | lemoval from State | cemetery, crei | matory or other place | e) | 11/29 | | | | |
| Ħ | artmer ortant injury | | 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens | | 25 | rematory 2. Name and Addres | s of Facility | 2005 ⁻ | - | Balt | imore, | Maryland |
| Ba | Depar Impo eny ir | | Mirail C. S. | 10,000 50 | E | ruzdzinsk 407 old E | i Fur | ieral | Home : | PA Essex | . Marv | land 21221 |
| | 5 1 | | 23a. Part1. Enter the disease, or composhock, or heart failure. List only o | cations that caused the dea | | | | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Myo cardio | il infan | tion | | | | | | Onset and Death 20 days |
| | /Medical Examiner | | resulting in death) | Due to (or as a conse | | | | | | | | |
| | | -e | Sequentially list conditions, if any, leading to immediate | Due to (or as a conse | iquenes of): | | | | | | | |
| K_ | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | |
| 0, | ate be executed hysician and the burial-transit | | resulting in death) Last | Due to (or as a conse | equence of): | | | | | | | |
| 8760, | ate be hysici the bu | lcal | | d | | | | | | | | |
| x 68 | that the death certificate ed by the attending phys detached for use as the | Physician/Med | IF FEMALE: | 23c. If yes, outcome of preg | nancv | | | | | 22 | d. Date of deli | wen/ |
| Вох | atten I for u | clan | in the past 12 months? | 1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of | tal death 3 | Ectopic pregnancy Other (specify) | | | | 23 | Month | Day Year |
| o. | t the d by the | hysl | 1 Tyes 2 No 9 Unknown | 9□ Unknown | | | | | | | | |
| ls, P | 8 g e | þ | Part II. Other significant conditions co | ntributing to death but not re | sulting in the u | inderlying cause give | en in Part I. | | | | | the cause of death? |
| örc | w requir been si should | ompleted | | | | | | | 24a. Was | | | |
| Rec | The law ate has page 2 t | d L | | | | | | | auto | osy irmed? | prior to death? | topsy findings available completion of cause of |
| tal | | ပို | 25. Was case referred to medical | | | | 26 Place | of Death | 1 ☐ Yes Check only | | 1 🗆 Yes | 2 X No |
| ţ Vi | di 5 | ToB | avaminar? | Hospital: 1 X Inpatient 2 | ☐ ER/Outpatie | nt 3 DOA Cthe | 05 | | | | ☐Other (Spec | cify) |
| 0 1 | ding Ph h. Alter th funeral | | 27. Manner of Death 1 XNatural 5 ☐ Pending | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | Work | | | d. Describe | how injury | occurred | |
| Sio | Attending r death. ector: Alter by the fune | cat | 2 Accident investigation 3 Suicide 6 Could not be | 29e Place of Injury . At | homo form et | | Yes 2 1 | No 28 | of Location / | Street and | Number or Pu | ral Route Number, |
| Division of Vital Records, | after a Direct | ertification: | 4 ☐ Homicide determined | 28e. Place of Injury - At building, etc. (Spec | | reet, factory, office | | | City or To | wn, State) | NUMBER OF THE | rai rioule reamber, |
| _ | To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the | O | 29a. Certifier 1 🛣 Certifying Phy (Check only 2 🗍 Medical Exam | sician: To the best of my kiner: On the basis of exami | nowledge, deat | th occurred at the time | ne, date an | d place, an | nd due to the | cause(s) a | ind manner as | stated. |
| | To the H within 24 To the F complete | Medical | one) | and manner stated. | | 29c. License | | | 1 | | signed (Monti | |
| | To To | - | 29b. Signature and title of certifier | 1 | us x | AT 24 | | 6-F6 | | 230. Date | 11/23/01 | |
| | 12 | | 30. Name and address of person who c | ompleted cause of death (It | em 23a) (Tvpe | | 10014 | | | | (1/45/0. | |
| | 10 | | Walid Barbour, | | | | Tel | 410- | -554 - | 2284 | ŀ | |
| | Sta | | 31. Date filed (Month, Day, Year) | Union Mem 32 Aegistrar's Sig | nature | ade | | | | | | |
| | Regist | rar | NOV 2 9 20 | UJ DERGER . | 10 19 | | | | | | | |

| | | - | For State Registrer | State of Ma | | partment of F ertificate of | | | 2e005 | 38153 |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------|
| ı | Physicia | _ | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | Physici: /Medic | al | Katherine | | 11en | | | | 22, 2005 | 9:30 A M |
| | Examin Funeral Director | Ŭ. | 4a. Facility Name (If not institution, give structure) Genesis Healthcar 5. Social Security Number 6. Sex 218–20–1827 | e-Layhil | 1 Center (In yrs. last birtho | Silver (ay) If Under 1 Year | Hours Min. | 8. Date of Birth (Month, Day, Y April 16 | 4c. County of De. Montgome (ear) 1914 Ca | ry inthplace (State or Foreign country) |
| | pur * | | Usual Residence of Decedent 10a, State 10b, County | | 10c. City, Town o | r Location | | | | 10d. Inside City Limits |
| | Maryle f sho | ō | Maryland Montgomery | | Silver | | | | | 1 ☐ Yes 2 ★No |
| | 28e | Director | 10e. Street and Number | / | DITAGE | 10f. Zip Code | | 100 | g. Citizen of What C | Country? |
| | h with | | 3227 Bel Pre Road | | | 20906 | | | U.S.A. | |
| 36 | s 1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. It heath and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumstic event, Item Medical Ever, I writing the colling at | by Funerai | | 2. Was Decedent Example Forces? 1 Yes 2 No. If Yes, Give | ver in U.S. | 13. Was Decedent of H If Yes, specify Cub | Hispanic Origin? (Spean, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - Arr Black, Wh | |
| Maryland 21215-0036 | thour | ed b | 15. Decedent's Educa | Year or Dates: | 16a. D | ecedent's Usual Occur | pation | 16 | Sb. Kind of Busines | White s/Industry |
| 215 | within 72 ene. than "net | Completed | (Specify only highest grade Elementary/Secondary (0-12) | | | ecedent's Usual Occup Give kind of work done 'e. DO NOT use retire | during most of work d) | ing | 35. Time of Business | amadany |
| 7 | filed wit Hygiene other the | Com | 12 | 0011090 (1 4070) | ['] Re | gistered N | urse | | Medical | |
| Ind | be file | Be | 17. Father's Name (First, Middle, Last) | | | | | e (First, Middle, Ma | | |
| ž | should be ind Mental s marked o | ^L | Fred Becker 19a. Informant's Name/Relationship (Type | a Print) | 10h A | lailing Address (Street | | helmina I | | Tie Code) |
| S | and 2 sho salth and n 27 is m | | Clinton Adams/Perso | • | | 8 Lake Dr. | | | | Zip Code) |
| <u>6</u> | s 1 and f Health item 27 other tr | | 20a. Method of Disposition | - - | 20b. Place of D | isposition (Name of crematory or other pla | | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | Oc. Location - City of | r Town, State |
| E | Pages nent of nnt: If its iry or o | | ty Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify) | moval from State | | ncoln Ceme | · 1 | H | Brentwood | , MD |
| Baltimore, | permit. Pages 1 an Department of Heat Importent: If item 2 eny injury or other once. | | 21. Signature of Funeral Service License | le | | 22. Name and Address | ensbure rd | t Lincolr | runeral | Home |
| Ment | rnysician /Medical Examiner | ner | 23a. Part Enter the disease, or complice shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury) | Due to (or as a | the death. Do not | enter the mode of dyi | ng, such as cardiac o | or respiratory arres | | Approximate Interval Between Onset and Death |
| 68760, | tificate be executed ig physician and as the burial-transit | edicai Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | consequence of) | | | | | |
| O. Box | The law requires that the death certi tte has been signed by the attending bage 2 should be detached for use a | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknowh | c. If yes, outcome of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of | Fetal death | 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _ | у | | 23d. Date of di Month | elivery Day Year |
| ords, P. | w requires that been signed to should be det | by | Part II. Other significant conditions cont | ributing to death but | t not resulting in t | e underlying cause gr | ven in Part I. | 23e. Did toba 1 ☐ Yes | Section 1 | to the cause of death? Probably 4 □Unknown |
| Vital Records, | | Completed | | | | | | 24a. Was an autopsy performe 1 Yes 2 | prior to death? | autopsy findings available completion of cause of us 2 \(\sum \) No |
| <u>=====================================</u> | Physicien: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | spital: | | Ott | | (Check only one) | | |
| of | Phys or this sral dii | .: To | 1 ☐ Yes 2 2 No 27. Manner of eath | 1 Inpatient | / 28b. Tin | e of 28c. Inju | ry at | me 5 Resident 28d. Describe how | ce 6 Other (Sp | ecify) |
| on | Attending or death. | atior | Natural 5 Pending investigation | (Month, Day | Year) Inju | ry Wo | rk?]Yes 2 □No | | | |
| Division of | in Dist | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injur building, etc. | ry - At home, farm (Specily) | , street, factory, office | | 28f. Location (Stre City or Town, | | Rural Route Number, |
| | he Hospitel or in 24 hours afte he Funerel Dir pletely filled in | edical | 29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) | cian: To the best of er: On the basis of and manner stat | examination and/i | leath occurred at the ti or investigation, in my o | ime, date and place, opinion, death occurr | and due to the cau red at the time, date | se(s) and manner a e and place, and du | as stated. ue to the cause(s) |
| | To the within 2 To the complet | Σ | 29b. Signature and title of certifier | An | | 29c. Licens | | | d. Date signed (Mor | |
| , | 4 | | , I mene | Klivel | an D | 103 | 8262 | 7 | Jov 28 | , 2005 |
| | | | 30. Name and address of person who con | RATTA | 2401 | Paulan | ch BLV | D Suit | e 330 P | , 2005 bckulle nn 20853 |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | 32. Registra | r's Signature | Specie | | | | |

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

| | | • | For State Registrar | State of Ma | ıryland / | Departi Certif | ment of H <i>icate of L</i> | ealth and D <i>eath</i> | d Mental Hy | giene Rag. No | 000 | 38155 |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------|-------------------|-----------------------------------|----------------------------|--------------------------------------------|------------------|-----------------------------|----------------------------------------------------|
| | Physicia | | 1. Decedent's Name (First, Middle, Las. | | - | | | | 2. Date of De | | Y Year | 3. Time of Death |
| | /Medic | al - | Ronald W. 4a. Facility Name (If not institution, give | Bens | son | 41 | o. City, Town, or | Location of De | Novemb | | 26 2005 County of Dea | |
| | Examin | er | 8015 Pine Ridge | | | | - | sadena | 60(1) | | Anne Ar | |
| | Funeral | | 5. Social Security Number 6. Se | | (In yrs. last b | M | Under 1 Year onths Days | If Under 24 H | Hrs. 8. Date of Bir | th | 9. Bir | thplace (State or Foreign ountry) |
| | Director | - | 216-40-0983 | AIM ZUI | 63 | Yrs. | | | Sept. | 16 1 | 1942 | MD |
| | yland how | | 10a. State 10b. County | | 10c. City, To | wn or Locati | on | | | | | 10d. Inside City Limits |
| | 8a-f | ecto | | rundel | | | Pasa | dena | | | | 1 ☐ Yes 2 ☒ No |
| | with to | Funeral Director | 10e. Street and Number 8015 Pine Ridge | Road | | | 10f. Zip Code 2 ' | 1122 | | 10g. Cit | izen of What C USA | ountry? |
| | death | nera | 11. Marital Status | 12. Was Decedent 8 Armed Forces? | Ever in U.S. | 13. Was | Decedent of Hi | spanic Origin? | ? (Specify Yes or No uerto Rican, etc.) | >- | 14. Race - Am Black, Whi | |
| 21215-0036 | be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or liema 23a or 28a-f ehow event, the Medical Ezatring must be notified at | þ | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: | lo | | Yes 2∑ No | Specify: | deno Fricari, etc.; | | - | White |
| 5-0 | 72 hc "natur | Completed | 15. Decedent's Ed (Specify only highest grad | ucation de completed) | 16 | a. Decedent | 's Usual Occupa of work done | ation furing most of | working | 16b. K | ind of Business | s/Industry |
| 121 | within lene. than " | дшо | Elementary/Secondary (0-12) | College (1-4or 5 | +) | | NOT use retired Police | | er | | MTA | |
| קס | be filed ntal Hygi od other event, I | BeC | 17. Father's Name (First, Middle, Last) | | | | | | Name (First, Middle | | , | |
| Maryland | 2 should b and Menti is marked raumatic e | To | Jesse Hugh | | | | | Virgir | | | chford | |
| <u>a</u> | nd 2 sh Ith and 27 is n traun | | 19a. Informant's Name/Relationship (7 Cindy Benson (| spouse) | 15 | • | | | <i>r Rural Route Numb</i> ad, Pasade | | | |
| re, | ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic | | 20a. Method of Disposition | | 20b. Place cemet | of Dispositio | | | Date 29 | | ocation - City o | |
| Baltimore, | Pages ment of tant: if it jury or o | | 1 ☐ Burial 2 【XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify | | | Crem | atory I | nc | 2005 | | | Maryland |
| Ball | permit. Pages Department of I important: if Itu any injury or or once. | | 21. Signature of Fineral Service Licen | | | 22. N | ame and Addres | | Stall n Road, Pa | | | 1 Home, P.A. 21122 |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | lications that caused on cause on each lin | the death. Do | o not enter t | ne mode of dyin | g, such as car | diac or respiratory a | ırrest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | r II | Immediate Cause (Final disease or condition resulting in death) | a | PD | 0 | | | | | | >20 yrs |
| | Examiner | | | Due to (or as | a consequenc | e or): | | | | | | |
| | P # | Iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as | a consequenc | e of): | | | | | | |
| | ficate be executed physician and is the burial-transit | Exami | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as | a consequenc | e of): | | | | | | |
| 68760, | te be e ysiciar ie buri | edical E | (| d | | | | | | | | |
| | ertifica ing phy e as th | Medi | IF FEMALE: | -0.1/ | , | | | | | | | |
| . Box | The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal dea | | topic pregnancy ther (specify) | | | | 23d. Date of de Month | alivery Day Year |
| P.0 | that the de led by the detached | Phys | 9 Unknown Part II. Other significant conditions of | | ut not reculting | in the unde | rhina couco an | on in Part I | 23e Dirt | tohacco | use contribute | to the cause of death? |
| ds, | uires ti signe id be c | d by | Tarrit. Other significant contamons of | Sittibuting to doubt b | at not resulting | in the dide | riying cause giv | orrary divis | _ | | | Probably 4 Unknown |
| of Vital Records, | law requir as been si 2 should I | Completed | | | | | | | 24a. Was | | 24b. Were a | utopsy findings available |
| l Re | | Com | | | | | | | auto perf | ormed? | death? | completion of cause of s 2 \(\sime\) No |
| Vita | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | aci post Oth | 00 | Death (Check only | | | |
| | Phys this aldi | n: To | 1 ☐ Yes 2 🔀 No 27. Manner of Death | 1 ∐ Inpatie | ont 2 ER/0 | . Time of | 28c. Injun | y at | ng Home 5 Res 28d. Describe | | | ecify) |
| ion | ending I sath. or: After he funer | atlo | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation | | y rear) | Injury | M 1 🗆 | Yes 2 □ No | | | | |
| Division | s after de il Directo id in by th | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Inj building, et | ury - At home, c. (Specify) | farm, street | , factory, office | | 28f. Location City or To | | | Rural Route Number, |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical C | | ysician: To the best niner: On the basis of and manner sta | examination : | | | | | | | |
| | To th within To th compl | Me | 29b. Signature and title of certifier | anlin | 2 0 | | 29c. Licens | e number | | 29d. Da | ate signed (Mor | nth, Day, Year) |
| | Z/ | | /swan E | usug r | nD_ | | 1776 | 141 | | i l | 12911 | 05 |
| | 10 | | 30: Name and address of person who SUSAN EO | sley n | ND | 244 | nt) mag | othy? | Beach | Rd | Pasa | dena miss |
| | Sta Regist | | 31. Date filed (Month, Day, Year) | 32. Registr | ar's Signature | Son | we | ٧ | | | | |
| | | | NIIV & 3 ' | 2000 | 19 50 | | | | | | | |

Box 68760, Division of Vital Records, P.O. or Attending Physicien: nours after death. ineral Director: After this y filled in by the funeral di To the Hospitel within 24 hours a
To the Funeral C
completely filled

Certification: To Be examiner? 1 Yes 2 □ No Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number

novan, mb J. Crossum OU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. CROSSAN O'DUNOVAW, MD 2112 DUNDALK AVE

BALTO 21222

State Registrar

31. Date filed (Month, Day, Year) 2005

29b. Signature and title of certifier



007632

| | | 1 | For State Registrar | State of Ma | arylan | d / Depa | artment rtificate | of H | ealth a | and M | | gierje Reg. No. | 005 | 38157 |
|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------|-------------------------------------------------|----------------|-------------------------------|--------------------------|------------|--------------------------|------------------------|---------------------------------|--------------------|---------------------|-----------------------------------------------------|
| | | | Decedent's Name (First, Middle, Las | 1) | | | | | | | 2. Date of De Month | | Year | 3. Time of Death |
| Н | Physicia | | Henry H. | $B\mathbf{lue}$ | | | | | | | 11 | 19 | | 5 3:10 P M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | street and number) | | | 4b. City, 7 | Town, or | Location o | f Death | | 4c. (| County of Dea | |
| ш | Ladimi | • | Good Samaritan | Hospital | | | B | alti | more | | | | N/A | |
| | Funeral | | 5. Social Security Number 6. Se | 7. Age | | ast birthday) | If Under Months | | If Under | 24 Hrs. Min. | 8. Date of Bir | th v. Year) | 9. Bir | tholace (State or Foreign ountry) |
| | Director | | 238-18-7387 | M 2□F | 92 | Yrs. | WOUTHIS | Days | 110010 | | MAR 18 | 1913 | 3 | NC |
| | D . | | Usual Residence of Decedent | | 10a Cib | , Town or Lo | antina . | | | | | | | 10d. Inside City Limits |
| | ahow | _ | 10a. State 10b. County | | | | | | | | | | | 1 SaYes 2 No |
| | Be-1 a | cto | | I/A | Вал | ltimor | | | | | | 10. 0::: | | |
| | ith th | Dire | 10e. Street and Number | | | | 10f. Zip | 212. | 20 | | | Tog. Citiz | en of What C USA | ountry? |
| | within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f ahow Ira Medical Examinal mual be notified at | Funeral Director | 1535 Northbourne | | | 0 10 | Was David | | | -:-0 /C- | | . 1 | 4. Race - Am | orican Indian |
| | tams | nue | 11. Marital Status | 12. Was Decedent Armed Forces? | | S. 13. | lf Yes, spec | fy Cubar | spanic Ori n, Mexican | gin? (Spi i, Puerto | ecify Yes or No Rican, etc.) |)^ ' | Black, Whi | |
| 36 | s afte | by F | 1 ☐ Never Married 2 ☐ Married 3 🗙 Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ N If Yes, Give Year or Dates: | WWI | т | 1 ☐ Yes 2 | No No | Specify: | | | | Specify: | black |
| 21215-0036 | hour | pe pe | 15. Decedent's Ed | | WWI | | dent's Usua | I Occupa | ation | | | 16b. Kir | nd of Business | |
| 5 | "na | Completed | (Specify only highest gra- | de completed) | | (Give | kind of wor DO NOT us | k done d | <i>furina</i> mos | t of work. | ing | | | , |
| 12 | withi ene. than | mc | Elementary/Secondary (0-12) | College (1-4or 5 | i+) | Truck | Drive | er | | | | U.S. | Gover | nment |
| 0 | Hygie other ent, | Ö | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mothe | r's Name | e (First, Middle | Maiden | Sumame) | |
| au | d be ental ked c | To Be | Doc | | В. | lue | | | Mat | tie | | Unk | | |
| Maryland | 2 should be i and Mental I Is marked or raumatic eve | - | 19a. Informant's Name/Relationship (7 | ype, Print) | | 19b. Maili | ng Address | (Street a | and Numbe | er or Run | al Route Numb | er, City or | Town, State, | Zip Code) |
| <u> </u> | nd 2 :: Ith ar 27 Is | | Lena Blue-Bumgard | lner - dau | ghtei | 153 | 5 Nor | thbo | urne. | Ba] | Ltimore | . MD | 21239 | |
| ē, | Health tem 27 l | | 20a. Method of Disposition | | 20b. P | lace of Dispo emetery, cre | osition (Nam | ne of | | | Date | | cation - City o | Town, State |
| JUO | Pages nent of I ant: If Ite ury or o | | 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | sapeake | | | | 1/25 | 5/2005 | Be1t | sville | . MD |
| Baltimore, | | | 21. Signature of Funeral Service Licen | | 10.2 | | | | | | ohrmann | | | , |
| Ba | Departr Departr Import any inj | | Huly | | MO098 | 36 | AFA, 1 | step | nen L Past | Lires | onrmann Drive | , PA | rson M | D 21286 |
| | | | 23a. Part1. Enter the disease, or comp | olications that caused | the deat | n. Do not en | | | | | | | | Approximate Interval Between |
| | Discortations | | shock, or heart failure. List only immediate Cause (Final | one cause on each III | ne. | | | | | | | | | Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a. Due to (or as | a consen | neuce of). | | | | | | | | |
| М | Examiner | | | 550 10 (6. 54 | | | | | | | | | | |
| | | e | Sequentially list conditions, if any, leading to immediate | Due to (or as | a conseq | uence of): | | | | | | | | |
| | uted d ansit | Examiner | cause. Enter Undertying Cause (Disease or injury that initiated events | C | | | | | | | | | | |
| Ć. | exec in an | Еха | resulting in death) Last | Due to (or as | a conseq | uence of): | | | | | | | | |
| 8760, | ate be executed hysician and the burial-transit | ical | | d | | | | | | | | | | |
| 9 | g ph) as th | | | | | | | | | | | | | |
| Вох | death certifica e attending ph of for use as ti | N/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome 1☐Live birth | | | ⊒Ectopic pr | egnancy | | | | 2 | 3d. Date of de | , |
| | death e atte d for | cia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4 Pregnant a | | | Other (sp | | | | | | Month | Day Year |
| P.O. | | Physician/Med | 9 Unknown | 9□ Unknown | | | | | | | | | | |
| | law requires that the deas been signed by the a | by P | Part II. Other significant conditions of | ontributing to death b | ut not res | ulting in the t | underlying c | ause give | en in Part I | • | 23e. Did | tobacco u | | o the cause of death? |
| ğ | w require been sig should b | | chrome Heart | Feilure | | | | | | | 1 🗆 | Yes 2[| □No 3□F | Probably 4 Unknown |
| ecords, | aw re s bec 2 sho | Completed | Prostato Cam | cer | | | | | | | 24a. Was | | 24b. Were a | utopsy findings available completion of cause of |
| α | sician: The law certificate has t irector, page 2 s | mo | 0. 1 7 | China | | | | | | | perfe | ormed? | death? | s 2 No |
| Vital | tifical tor, p | d) | 25. Was case referred to medical | fi a enry | | | | | 26. Place | of Deat | h (Check only | | | |
| > | > 0 | To B | examiner? 1 □ Yes 2 🛣 No | Hospital: 1 Inpatio | ent 2 | ER/Outpatie | nt 3 DC | Othe | er: 4 🗆 Nı | ursing Ho | ome 5 Res | idence 6 | 6 □Other (Sp | ecify) |
| Division of | Attending Physician: r death. actor: After this certific. by the funeral director, | | 27. Manner of Death | 28a. Date of Inju | iry v Year) | 28b. Time o | of 2 | 8c. Injun | y at | | 28d. Describe | how injury | y occurred | |
| jou | ttendin death. stor: Aft | atio | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation | | , , , , | , | М | | Yes 2 | No | | | | |
| vis | Atte | ertification: | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 28e. Place of In | jury - At h | ome, farm, si | treet, factory | , office | | | 28f. Location (| | | Rural Route Number, |
| | s afte | Cert | | Danagj o | | | | | | | | | | |
| | Hospitel (24 hours a) Funerel Ditely filled i | Sai | 29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar | ysician: To the best niner: On the basis of | of my kno | wiedge, dea | th occurred | at the lin | ne, date ar | nd place, | and due to the | cause(s) | and manner a | is stated. |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edicai | one) | and manner st | ated. | | | | | 000011 | . 54 41 1110 | | | |
| | To the within 2 To the compler | Σ | 29b. Signature and title of certifier | | | | 290 | | e number | | | | | oth, Day, Year) |
| | | | 1 di ul | J , ~ | 1. D. | | | RE | 5 00 | 00 | | 1 | 1/19 | 105 |
| | 180 | | 30. Name and address of person who | _ | death (iter | m 23a) (Type | , Print) | | | | | | 0 | |
| | 2, | | 5601 Loch | Raven | Boul | evard | , | Bar | Ltimo | re, | MD | 2/2 | 37 | |
| 1 | | ate | 31. Date filed (Month, Day, Year) NOV 2 9 200 | 92. Regist | rar's Signa | ature | | | | | | | | |
| | Regist | rar | MAA 5 3 500 | A Source | D | A STATE OF | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 055

| | | 1 | For State | State of Maryland | Department of Health and Certificate of Death | Mental Hygier Rag. N | -000 00100 |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------|
| | Physicis | | Registrar I. Decedent's Name (First, Middle, Las | " | Ralso | 2. Date of Death Month | 3. Time of Death |
| | Physicia /Medic | al _ | la. Facility Name (If net institution, give | street and number) | 4b. City, Town, or Location of Deat | h 4 | 4c. County of Death |
| | Examin | | Franklin Squ | are Hospito | hinthday If Under 1 Year If Under 24 Hrs | O. Data of Righ | Bo /timore |
| | Funeral Director | | 5. Social Security Number 6. S | 7. Age (In yrs. last | birthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Yea | 9. Birthplace (State or Foreign Country) MARYLAND |
| | ס | · - | Usual Residence of Decedent 10a. State 10b. County | 10c. City, T | own or Location | | 10d. Inside City Limits |
| | Maryla a-f sho | | A4 | MORE | Middle River. | | 1 ☐ Yes 2 17 No |
| | vith the | Direc | 10e. Street and Number | 1. CL | 10f. Zip Code | 10g. (| Citizen of What Country? |
| | death v ms 23e | Funeral Director | 11. Marital Status | 12. Was Decedent Ever in U.S. | 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer | Specify Yes or No- | 14. Race - American Indian, Black, White, etc. |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28a-f show important: If item 27 is marked other the Madical Eranit er must be multified at ancie. Once. | by Fur | 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced | Amed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: | 1 ☐ Yes 2 No Specify: | , | Specify: White |
| 215-0036 | 72 hour naturel | ted t | 15. Decedent's E. (Specify only highest gra | lucation 1 | 6a. Decedent's Usual Occupation (Give kind of work done during most of wo | | Kind of Business/Industry |
| 121 | within 7 iene. then "r | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | Manager | P | narmace. |
| 1d 2 | e filed al Hygi I other vent, I | Be Co | 17. Father's Name (First, Middle, Last, | 1 | 18. Mother's Na | me (First, Middle, Maid | len Sumame) |
| Maryland | 2 should be fi and Mental H Is marked of reumatic ever | 2 | HOLLU T, | Lewis | 19b. Mailing Address (Street and Number or R | ural Route Number, Ci | |
| | 1 and 2 s Health an Iem 27 Is o | | Ronald Bets | n (| 605 Crieksedge Ct | Middle | Kiver MD 21222 |
| Baltimore, | Pages 1 and the nent of He nert: If item | | 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ | Hemovai from State | e of Disposition (Name of letery, crematory or other place) | Pate 20c. | Location - City or Town, State |
| altim | permit. Pag Department Important: I any injury o | 1 | * 4 □ Donation * 5 □ Other (Special Signature of Funeral Service Lice | | 22. Name and Address of Facility | ALTIMORE, | MD 21234. |
| ä | Deparenti Importanti any ir | 1 3 | Kimberly 4. | autoling | EVANS FUNERALCH | | HARFOLD RO. Approximate |
| | | | 23a. Part1. Enter the disease, or consolors shock, or heart failure. List only Immediate Cause (Final disease or condition | one cause of each line. | Do not enter the mode of dying, such as cardia ISCLEMIO | to or respiratory arrest, | Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | a. Due to (or as a consequer | | - | A |
| | Examiner | e. | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a consequent | t / h + h in 10c | | |
| | nd transit | Examlner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disage or injury that initiated events resulting in death) Last | · ASCVI | | | |
| 68760, | eath certificate be executed attending physician and for use as the burial-transit | al Ex | resulting in death) Last | Due to (or as a consequent | nce oi). | | |
| _ | rtificate ng phys | Medical | JF FEMALE: | | | | |
| Вох | ath ce attendi for use | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea | eath 3 □Ectopic pregnancy | | 23d. Date of delivery Month Day Year |
| P.0. | at the de by the a | hysid | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | 22 pid tohan | co use contribute to the cause of death? |
| | s tha | by | Part II. Other significant conditions | contributing to death but not result | ing in the underlying cause given in Part I. | 1 ☐ Yes | |
| COL | aw require s been sig 2 should b | Completed | | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| II Re | | Com | | | | perförme 1 ☐ Yes 2 | death? |
| Vita | ysicien: Th is certificate director, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpatient | Othor | eath <i>Check on one</i> Home 5□ Residence | e 6 □Other (Specify) |
| n of | ding Phys h. After this funeral di | on; T | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 8b. Time of 28c. Injury at Work? | 28d. Describe how | njury occurred |
| Division of Vital Records, | t or Attending Physicien: after death. Director: After this certifici i in by the funeral director, | Certification: | 2 Accident investigate 3 Suicide 6 Could not | 28e. Place of Injury - At hom | M 1 ☐ Yes 2 ☐ No | 28f. Location (Stree City or Town, S | t and Number or Rural Route Number, |
| Div | tel or / rs after el Dire | Certi | 4 Homicide | building, etc. (Specify) | | | |
| | To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director. | Medical | 29a. Certifier (Check only one) (Check only one) | hysician: To the best of my knowl ninar: On the basis of examination and manner stated. | ledge, death occurred at the time, date and pla on and/or investigation, in my opinion, death oc | ce, and due to the caus curred at the time, date | e(s) and manner as stated. and place, and due to the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier | N | 29c. License number | 29d. | Date signed (Month, Day, Year) |
| | 10/ | | | a completed cause of death (learn) | D 00 5 4 7 30 | 5 | 21237 |
| | [0 | | 30. Name and address of person with | respected cause of death (item 2) | quare prive Balti | more, MP | 21237 |
| | Si Regis | tate trar | 31. Date filed (Morte, Pay, Year) | 32. Registrar's Signatu | M. Small | , | |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 0 5 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Blachowicz 1014 M NOUGMBER 2005 Janet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) Baltimore remoria MICO N 8. Date of Birth (Month, Day, Year) Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 25 F Months Days Hours 18 Director 219-05 -015 mory knc Usual Residence of Decedent 10d. tnside City Limits 10b. County 10c. City. Town or Location 10a State 27 is marked other then "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Tes 2 No Director MO tackville 21/more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BUC Apt. 40

12. Was Decedent Ever in U.S. Amed Forces

1 Yes 2 No
If Yes, Give Year or Dates: 8810 51531 517 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black, White, etc 1 □ Never Married 2 □ Married 1 Yes 25 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 h and Mental Hygiene. 7 is marked other then "m Elementary/Secondary (0-12) College (1-4or 5+) tomemaker Smot 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be mthon 10Knows ဥ telen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itsm 27 i , Audubon, PA Sanderling ircle 719 tatricia Marie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date Pages 1 permit. Pages
Department of I
Important: If its
eny injury or o 1 Suriat 2 □ Cremation 3 □ Removal from State 22. Name and Address of Fadility 800 ther Ford Road 4 □ Donation 5 □ Other (Specify) Maryland 21. Signature of Funeral Service Licenses Parkville MO tuneral Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final **Physician** MYOCARDIAL INFARKTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DISCASE ARTERY ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transit certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performs ATRIAL FIBRILLATION 2 No DIABETES MELITUS 1 Yes or Attending Physician: the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၀ 1 Monatient 2 FR/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Func Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified ATZ438946 25,2005 BO MO NOUEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL 31. Date filed (Month, Day, Year) 3 HOSTITAL, MD am 32. Pagistrar's Signature State NOV 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 21 2005 04:20 11 Burrell Theresa /Medical 4c. County of Dealh 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Bon Secours Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F Yrs. 54 07 04 ΜĎ Director 214-62-5179 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County •how Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If itam 27 is marked other than "nature!", or Items 23a or 28s-1 ehov ury or other traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Directo Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21223 2584 Edmondson Ave 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify: Maryland 21215-0036 Specify: Black 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service's 10th grade 17. Father's Name (First, Middle, Last) Cashier 18. Mother's Name (First, Middle, Maiden Sumame) Be Sylvia Burrell George D. Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2583 Edmondson Ave, Baltimore, Md 21223 Keisha Mosby-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department Important: If eny injury or Metro Crematory Inc 11/26/05 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee March for West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or head dilure. List only one cause on each line. 23a. Part1 shock Immediate Cause (Final Ma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. physician Physician/Medical as the l ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 7 %o
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached it P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes t diractor, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: diractor, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Yes 2 No ဥ s after death.
I Director: After this
of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No M investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours aft To the Funeral Di completely filled in etrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Firint) OU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2005 goods Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 15

| | | 1 | State of Maryland / Depart | ficate of Death | Reg. | No. |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------------|
| | Physicia | an | Decedent's Name (First, Middle, Last) | | Date of Death Month | Day Year 3. Time of Death |
| | /Medic | ål | James Wesley Bowen, II | | NOV. | 17 2005 10:45 AM |
| | Examin | GI | | b. City, Town, or Location of Death | | 4c. County of Death |
| | | *4 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | Baltimore If Under 1 Year If Under 24 Hrs. | 0.5 (5:4) | |
| | Funeral Director | | 216-44-1813 1ॼM 2□F 61 Yrs. | Months Days Hours Min. | 8. Date of Birth (Month, Day, Ye June 21, | 9. Birthplace (State or Foreign Country) 1944 Maryland |
| | and * | - | Usual Residence of Decedent 10c. City, Town or Local 10a. State 10b. County 10c. City, Town or Local | tion | | 10d. Inside City Limits |
| | lanyl i sho | ō | Maryland Baltimore | | | 1 v Yes 2 □ No |
| | 28a- | Director | 10e. Street and Number | 10f. Zip Code | 10g. | Citizen of What Country? |
| | with ta or | <u>a</u> | 2308 Pickwick Road | 21207 | | USA |
| | ns 2 | Funeral | | es Decedent of Hispanic Origin? (Sp 'es, specify Cuban, Mexican, Puerto | | 14. Race - American Indian, |
| Maryland 21213-0030 | be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Itams 23a or 28a-f show avent, the Mcdical Ever it ar must be notified at | by | 1 Never Married 2 X Married 1 X Yes 2 No | es, specify Cuban, Mexican, Puerto] Yes 2[☑] No Specify: | Hican, etc.) | Black, White, etc. Specify: White |
| 5 | 2 ho | ted | 15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir | nt's Usual Occupation | ing 161 | b. Kind of Business/Industry |
| 2 | within 7 ene. than "n | Completed | | nd of work done during most of work O NOT use retired) Resources | i | |
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| <u>a</u> | should be ind Menta s markad umatic av | 2 | James Wesley Bowen | | Gates-Sim | |
| ā | 2 sho and l | | , , , , , , , , , , , , , , , , , , , , | Address (Street and Number or Run | al Route Number, C | ity or Town, State, Zip Code) |
| | 1 and 2 Health tam 27 | - 1 | | Pickwick Road; B | | |
| Baitimore, | of f i | | 20a. Method of Disposition 1 Burial 2 ZiCremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposit cemetery, crema National C | | | c. Location - City or Town, State alls Church, VA |
| gaid | permit. Pag Department Important: I any injury o | | 21. Signatur Sheral Service Dicensee W. 11290 | Name and Address of Facility Ltzke Funeral Hon 630 Edmondson Av | ne of Cato | onsville, Inc. |
| 68760, | tificate be executed //Medical Examiner and as the burial-transit | edical Examiner | shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | of acute mye | loid leu | Interval Between Onset and Death Days |
| O. Box 62 | ath certif ittending for use as | Physician/Med | | ctopic pregnancy Other (specify) | | 23d. Date of delivery Month Day Year |
| 7 | uires that the de signed by the a Id be detached I | by | Part II. Other significant conditions contributing to death but not resulting in the und | erlying cause given in Part I. | | cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown |
| Vital Records, | The law require ate has been si page 2 should I | Completed | | | 24a. Was an autopsy performe | 24b. Were autopsy findings available prior to completion of cause of death? No 1 se 2 \sum No |
| ta | | a) | 25. Was case referred to medical | 26. Place of Deat | h (Check only one) | |
| 5 | ys dii | To B | examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient | 3 DOA Other: 4 Nursing Ho | ome 5 Residence | ce 6 □Other (Specify) |
| ō | | | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of (Month, Day Year) | 28c. Injury at Work? | 28d. Describe how | injury occurred |
| 0 | ttending F death. ctor: Alter y the funer | atic | 2 Accident investigation | M 1 Yes 2 No | | |
| Division | al or Attendation after death Poirector: | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) | ot, factory, office | 28f. Location (Stree City or Town, S | et and Number or Rural Route Number, State) |
| | To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune | Medical C | 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the | | | |
| | ro th vithin ro th | Me | 29b. Signature and title of certifier | 29c. License number | 29d | . Date signed (Month, Day, Year) |
|) | ->F0 | 1 | VIJAGA MO.PhD | D 5 8309 | N | ovember 17, 2005 |
| , | Jox, | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Prince of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont | rint) thent Pathology. | St. Agnes A | Date signed (Month, Day, Year) Ovember 17, 2005 Ospital, Baltmore, MD |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 2 9 2005 32. Registrar's Signature | adi | | , |

EWEN, JAMES W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2005 Month Anita Frances Bartnik Nov. 21, 9:20 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Catonsville 1912 Branston Road Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 5, 1918 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🛛 F 220-07-4139 87 Maryland Usual Residence of Decedent 10c. City. Town or Location 10b. County 10a, State 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1912 Branston Road 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No !f Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Blair, Sr. Annie Falter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Bartnik, Son 6225 Latch Lift Ct., Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11-26-2005 Baltimore, Maryland Loudon Park Cemetery ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, 21. Signature of Funeral Service License 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congetive disease or condition resulting in death) Due to (or a consequence of): Uremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 5+ Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 ☐ Other (specify) . 4□Pregnant at time of death 9 Unknown

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23g

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natural

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Pages 1 and 2 s nent of Health an ent: If item 27 Is

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72 hours after

Baltimore, Maryland 21215-0036

Director

Funerai

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other traumatic event, the Medical Examiner must be notified at

Examiner

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Box 68760 the nse jo P.O. detached à peen s

certificate be executed burial-transit attending physician Division of Vital Records, this e Hospital or Attending P 24 hours after death. e Funeral Director: After t 24 hours a

Registrar

To the Within 2 State

Physician/Medical IF FEMALE: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed Be 25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 2 27. Manner of Death 1 Natural 2 Accident 3 🗀 Suicide 4 | Homicide 29a. Certifier

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

29c. License number 45

Suite

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy 1 Yes

Other: 4 ☐ Nursing Home 5 ⚠ Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

107

2 No

28d. Describe how injury occurred

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

516 N-Rolling Rocal MAUNG 0

31. Date filed (Month, Day, Year) 32. Signature NOV 2 9 2005

State of Maryland / Department of Health and Mental Hygiene 05 38163 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 27, 2005 Arthur November 6:30 A Bradford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Eldercare Randallstown Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. Director 216-05-5171 June 23, 1911 South Carolina Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: if item 27 is marked other than "natural; or items 23a or 28a-1 shov ury or other traumatic event, "he Madical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director **Brooklyn** New York Kings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2749 Linden Blvd. 11208 United States of American Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐XNo Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Widowed 4 □ Divorced Specify Black If Yes, Givo Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ordained Minister Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Saunders Bradford **Alice** ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3914 Chaffey Road, Randallstown, Maryland 21133 Paulette S. Turner (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Department of important: if any injury or once. P.O.Box 2966Baltimore 11/29/05 * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133 W HWIJT 23a. Part1. Exter the disease, or shock or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, sign be t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an 1 Yes 27 Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide within 24 hours a
To the Funeral C 29a. Certifier 1 Cocifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29d. Date signed (Month, Day, Yea 29b. Signature and title of certifier 23a) (Type, 30. Name and address of person who completed cause of death (Item) M. HOWART other 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra 2005 9

State of Maryland / Department of Health and Mental Hygie 0 0 5 1- State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item #31 Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST (State Registrar Amend Item Per FH C849 10 POST 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19, 2005 William Amos Bratcher, Sr. November 3:20 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2444 Augusta Road Manchester Carroll 5. Social Security Number 224-48-7122 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Jan. 24 Birthplace (State or Foreign Country) Year) Days Hours 1 🔀 M 2 🗆 F 66 Yrs. 1939 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland N/A Director Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3636 Keswick Road 21211 or items 23a USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Examinat Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Self Employed Flooring Installer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conrad Bratcher Ann Elizabeth Ward ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilhemina C. Bratcher 3636 Keswick Road Wife Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11/23/2005 Catonsville, Maryland Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 21. Signatur of Foneral Service I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day 5 Other (specify) P.O. the 9 Unknown 9 Unknown à s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s 20 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner DAUGHUELS Hospital: Other: 4 Nursing Home 5 Residence 6 Other 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 V atural 5 Pendina within 24 hours after death.

To the Funeral Director: A completely filled in by the f death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 02974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 S.E Crain Hay Glen Burnie, MD 2061 ala 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygie 20 0 5 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:33 A^M Donald Floyd Bunn November 23, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 504 Country Walk Court Bel Air If Under 1 Year | If Under 24 Hrs. 8. Oate of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1⊠M 2□F 55 230-64-1994 Yrs. Director Dec.28, 1949 Virginia Usual Residence of Deceden death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County itam 27 is marked othar than "natural", or itams 23a or 28e-f show other traumatic avent, the Medical Example in its interest by motified at 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 Country Walk Court 21015 12. Was Decedent Ever in U.S. Armed Forces? 1.☐Yes 2.☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itar any injury or other traumatic avent, the Medical Examena 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Oil Sales Vice President Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donald Floyd Bunn Dorothy Katherine Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Country Walk Court, Bel Air, Maryland 21015 Karen Bunn - Wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Bel Air Mem. Gardens 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/28/05 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee YHayle ? 1317 Cokesbury Road, Abingdon, Maryland 21009 1317 Cokesbury Road, Abingdo:
a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Failure SIXMONTH /Medical Due to (or as a conseque Dighetes Mellitus Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician ned for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 X No tha Hospitel or Attanding Physician: in 24 hours after death. the Funerel Diractor: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specity) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 2 D33642 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) Beltor MD 2/014 Nevin 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature Registrar

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| cal ner | 4a. Facility Name (If not institution, give s | | | 4b. City, Town, | or Location of Death | | 7 | ty of Death |
| G. | Chesapeake Hospic | | | Linth | icum | | Anne | Arundel |
| LCC- | 5. Social Security Number 6. Sex | 7. Age (II | n yrs. last birthday) | If Under 1 Year Months Days | | 8. Date of Birth (Month, Day, | 1925 | Birthplace (State or Figure 1) Country) |
| | 217-14-0923 | M 2\\F 80 | Yrs. | Months Buys | 110010 | 2-12-2 0 | 95 | MD |
| | Usual Residence of Decedent 10a. State 10b. County | 10 | Dc. City, Town or Lo | ocation | | | | 10d. Inside City I |
| 5 | | | _ | | | | | 1 ☐ Yes 2 |
| Director | MD Anne Aru | ndel | Severn | 10f. Zip Code | | 10 | Da. Citizen of | f What Country? |
| | | | | | | | U.S.A | |
| Funeral | 771 Stevenson Roa | 12. Was Decedent Eve | rin U.S. 13. | 21144 Was Decedent of | Hispanic Origin? (Sp | ecify Yes or No- | 14. Ra | ace - American Indian, |
| 퉏 | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 🗓 No | | | oan, Mexican, Puerto | Rican, etc.) | | lack, White, etc. White |
| ρ | | If Yes, Give Year or Dates: | | 1 ☐ Yes 2Ñ No | Specify: | | Spec | ify: WILLE |
| Completed | 15. Decedent's Edu (Specify only highest grade | | | dent's Usual Occu | pation during most of work | | 6b. Kind of | Business/Industry |
| npie | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retire | | | | |
| Co | 12 | | Bea | utician | T - 2 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 | (F) . A4: (// A | Beau | |
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| | 19a. Informant's Name/Relationship (Ty) | | | | t and Number or Rui | | - | |
| | Harry James Brown / Son 1084 Plum Creek Drive; Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20c. | | | | | | | |
| | 1 ⊠Burial 2 ☐ Cremation 3 ☐ R | lemoval from State | cemetery, cre | matory or other pla | | | | |
| | 4 Donation 5 Other (Specify) 21 Signature J Funeral Service License | | | | | | | Burnie, MD |
| | 21. Signatured Fulleral Service Little 19 | 1 004 | - (| | Ave SW; G | _ | | |
| | 23a. Part 1. Enter the disease, or compli | | | | | | | Approximate |
| | shock, or heart failure. List only or Immediate Cause (Final | ne cause on each line. | | | | | | Interval Betwee |
| | | 1161 | - 1 .het- 1 | | | | | |
| | disease or condition resulting in death) | 1 | | Cuu | arla eA | MOLER | | |
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| ja . | resulting in death) Sequentially list conditions, if any, leading to immediate | 1 | onsequence of): | | de la | HO CER | | |
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To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit Division of Vital Records, P.O. Box 68760,

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Pnysician /Medical Examiner

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifies

J 560 32 Registrar's Signature ROSENKHE 31. Date filed (Month, Day, Year) NOV 2 9 2005

30. Name and address of person who completed Juse of death (Item 23a) (Type, Print)



MO

29c. License number

D5812

2000

29d. Date signed (Month, Day, Year)

HART HO 81239

Look luck . vol

State of Maryland / Department of Health and Mental Hygiepe 05 1 - For State Registra Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 24, 2005 5:35A Catherine Elizabeth Buchanan November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Montgomery Rockville 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Months 1 ☐ M 2X☐ F 1941 Oklahoma Director 64 440-42-6079 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-1 ahow other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2X No Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20878 9 Freas Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 2 should be filled within 72 hours after n and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Executive Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Smith Daniel Snider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an item 27 is Michael Buchanan/Husband 9 Freas Court, North Potomac, Maryland 20878 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State November permit. Pages 1 Department of H Important: If ite any Injury or ott 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Prium, Inc. 27, 2005 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 27, 2005 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature The ral Service Licen M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to for as a consequence of Examiner use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. cete has been sig , page 2 should b 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has 2X No 1 ☐ Yes Division of Vital Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4□ Nursing Home 5□ Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 📉 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After it 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Charles Harrison, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 9 2005 PARMEN Registrar

| | | | For State | State of Maryland / Department of Healt | | al Hygierne | 005 | 38168 |
|------------|----------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------|---------------------------------|-----------------------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Las | Certificate of Dea | | Reg. No. te of Death | | 3. Time of Death |
| | Physici /Medic | | Pearlene | Bailer | NO | Vember Day | 26.200 | 5 3:43 |
| | Examin | | 4a. Facility Name (If not institution, give | 11. D 11. | | | County of Death | 1 |
| | Francis | | 5. Social Security Number 6. Se | x 7. Age (In yrs. last birthday) If Under 1 Year If Ur | MOTE Inder 24 Hrs. 8, Da | e of Birth | N/A Birth | nplace (State or Foreign |
| ь | Funeral Director | | | M 2×F 63 Yrs. Months Days Hou | urs Min. De | te of Birth onth, Day, Year C. 29.19 | 41 10 | iruland |
| | and . | | Usual Residence of Decedent 10a. State 10b. County / | 10c. City, Town or Location | | | | 10d. Inside City Limits |
| | Maryl | ţō | Maryland NIA | Baltimore | | | | 1 X Yes 2 □ No |
| | th the or 28a e noti | Director | 10e. Street and Number | 10f. Zip Code | | 10g. Citiz | zen of What Cou | untry? |
| | s 23a | ral | 1027 Cathe | Gral St. 15H 2/26 |)2 | | USA | |
| ' O | r Rem | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ØNo | ic Origin? (Specify Ye exican, Puerto Rican, | es or No- etc.) | 14. Race - Amer Black, White | |
| 215-0036 | 72 hours atter death with the Maryland natural', or Items 23a or 28a-f show lical Examinat must be natified at | by | 3 X Widowed 4 □ Divorced | | ecify: | | Specify: BI | acK |
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| 212 | filed within Hygiene. Ither than "Int, I'm Mac | omp | Elementary/Secondary (0-12) | College (1-40r5+) Homemat | Ker | 1 | Juln | Home |
| nd | be filed Ital Hygid Ital Other Avant, II | Be C | 17. Father's Name (First, Middle, Last) | 18. N | Mother's Name (First, | Middle, Maiden | Sumame) | |
| Maryland | should be and Mental markad o umatic ava | ^L | Kuben G | reen G | eorgeti | a Pi | itney | |
| Ma | and 2 she ealth and n 27 Is m | | 19a. Informant's Name/Relationship (7) | 4rm Strony 5629 Govan | e Ave. | Po 1+ | NAA | 21212 |
| ore, | - ± a ≠ | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | 20b. Place of Disposition (Name of | Date | 20c. Loc | cation - City or T | own, State |
| altimore, | Pa Int | | '4 ☐ Donation 5 ☐ Other (Specify, | Trinity Cometery | 1243/20 | 05 DU | indal | K,Md. |
| Bal | permit. Pag Department Important: any injury once. | | 21. Signature of Funeral Service Licens | Joseph L. K | uss Fu | zeral 1 | tome, F | 2. A. |
| Γ | | | 23a. Pag V. Enter the disease, or comp | lications that caused the death. Do not enter the mode of dying, such ne cause on each line. | th as cardiac or respin | ratory arrest, | VIa. 21 | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Final disease or condition | a. Lunia CANCER | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequence of): | | | | |
| | , 000 | er | Sequentially list conditions, if any, leading to immediate | b. End Stage Perch Disco | se_ | | | Jakou La |
| | cuted nd ransit | Examlner | cause. Enter Underlying Cause (Disease or injury that initiated events | c | | | | |
| 60, | ficate be executed g physician and as the burial-transit | | resulting in death) Last | Due to (or as a consequence of): | | | | |
| 68760, | ficate physics the t | edical | | 1 | | | | |
| Box | eath certif attending for use as | M/UE | 23b. Was decedent pregnant | 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 3 □Ectopic pregnancy | | 2 | 3d. Date of deliv | ery |
| | The law requires that the death certile has been signed by the attending agge 2 should be detached for use | Physician/M | in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown | 4 Pregnant at time of death 5 Other (specify) | | | Month | Day Year |
| P.0 | that the dended by the a | | | ntributing to death but not resulting in the underlying cause given in P | Part I. 23 | e. Did tobacco us | se contribute to t | the cause of death? |
| Records, | w requires been sign should be | ed by | Dichetes Me | 1/1445 | | 1 Yes 2 |]No 3□Proi | bably 4 Unknown |
| eco | e law re has bee ge 2 sho | Completed | | | 24 | a. Was an autopsy | 24b. Were auto | opsy findings available ompletion of cause of |
| al R | | Con | | | 1 | performed? Yes 2 No | death? | 2□ No |
| of Vital | .≌ 8 ĕ | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No | Jacobali. | Place of Death (Chec | | | |
| | ding Phys h. After this funeral dir | - | 27. Manger of Death | 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 3 ☐ OA 4 ■ 28a. Date of Injury (Month, Day Year) | Nursing Home 51 28d. De | Scribe how injury | | <u>y)</u> |
| sior | Attandin death. ctor: Af y the fur | catlo | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | M 1 ☐ Yes 2 | | | | |
| Division | Hospital or Attanding 14 hours atter death. Funeral Diractor: After tely filled in by the fune | Certification: | 4 Homicide determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | ation (Street and or Town, State) | Number or Rura | al Route Number, |
| | To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b | | 29a. Certifier 1 Certifying Phy | sicien: To the best of my knowledge, death occurred at the time, dat | te and place, and due | to the cause(s) a | and manner as s | stated. |
| | To the Hi within 24 To tha Fi | Medical | Une) | ner: On the basis of examination and/or investigation, in my opinion, and manner stated. | | | | |
| | Cor With | _ | 29b. Signature and title of certifier | 29c. License numb | | 29d. Date | signed (Month, | |
| ,0 | ~ | | 30. Name and address of person who c | ompleted cause of death (Item 23a) (Type, Print) | 9056 | 111 | 28/05 | * |
| 9 | | | Dalject Sal- | 15 MD 1600 M. MT B | Rujel Au | e Bell | CM 3 | 21217 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | | | | |
| DH | MH 17 Rev 1/20 | 45 | NOV 2 9 2 | 005 Bloom It Spark | | | | |

ORIGINAL

3 43 m

PEARLINE

BAILEY

| | | | 1 - For State Registrar | State of Maryland / | Department of Health and Certificate of Death | | 2005 38169 |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| R. | Physici /Medi | | 1. Decedent's Name (First, Middle, La | BAGROWSZ | | 2. Date of Death Month | Day Year 3. Time of Death 23, 2005 3:30 A |
| | Examír | | 4a. Facility Name (If not institution, given North Arundel 5. Social Security Number 6. S | e street and number) Hospital | 4b. City, Town, or Location of D | eath | 4c. County of Death Anne Arundel |
| ************************************** | Funeral Director | | 218-18-7943 Usual Residence of Decedent | ØM 2□F 80 | Yrs. Months Days Hours N | Irs. 8. Date of Birth (Month, Day, Y | |
| | Ba-f show | ector | Md. Anne A | | wn or Location OVer | | 10d. Inside City Limits 1 ☐ Yes 2☐No |
| | with th | Dire | 10e. Street and Number | D. 1 | 10f. Zip Code | 10g | . Citizen of What Country? |
| 36 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene item 27 is marked other than "natural; or items 23s or 28s-1 show other traumatic event, the Medical Examination as possible as | by Funeral Director | 1136 Stoney R 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give | 21076 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 Yes 2 No Specify: | (Specify Yes or No- erto Rican, etc.) | USA 14. Race - American Indian, Black, White, etc. Specify: White |
| 215-0036 | in 72 hour n "natural ded cal Ex | Completed b | 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra | Year or Dates: ducation ide completed) 16 | a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) | vorking 16 | Specify: White b. Kind of Business/Industry |
| 7 | 2 should be filed within n and Mental Hygiene. Is marked other than raumatic event, the M | Be Com | Elementary/Secondary (0-12) 8th 17. Father's Name (First, Middle, Last) | College (1-4or 5+) | Sign Erector | lame (First, Middle, Ma | itzinger Sign Co |
| Maryland | d Menti d Menti narked | To I | Francis E. Ba | | | Dubiel | |
| | nd 2 st lith and 27 is r r traun | | 19a. Informant's Name/Relationship (Stella Bagrows | | b. Mailing Address <i>(Street</i> a <i>nd Number or</i> 136 Stoney Run I | | |
| ore, | | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | 20b. Place | of Disposition (Name of ery, crematory or other place) | | c. Location - City or Town, State |
| Baltimore, | permit. Pages Department of I Important: If its any injury or or once. | | 4 □ Donation |) Bayv | 22. Name and Address of Facility & | czorowski | altimore, Maryland Funeral Home,PA |
| Ĉ. | | | 23a. Part1. Enter the disease, or com | pligations that caused the death. Do | not enter the mode of dying, such as card | | Ltimore, Md21222 |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | | LTUNARY | | Onset and Death |
| Z. | cate be executed EXA physician and ithe burial-transit | al Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence | of): | 311 PS TC | m 20 yns |
| | B 문화 | /Medical | IF FEMALE: | .d. | | | |
| .O. Box | at the death certific by the attending p tached for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | n 3 □Ectopic pregnancy 5 □ Other (specify) | | 23d. Date of delivery Month Day Year |
| ords, P | signed d be de | by | Part II. Other significant conditions of | ontributing to death but not resulting | in the underlying cause given in Part I. | 23e. Did tobac | co use contribute to the cause of death? 2 No 3 Probably 4 Unknown |
| Reco | he law e has b age 2 sl | Completed | | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| TO TO | | | | | | performed | |
| Vita | | o Be | 25. Was case referred to medical examiner? | Hospital: 1 Innation 2 FEVO | Other | 1 ☐ Yes 2 Neath Check only one | No 1 □ Yes 2 □ No |
| n of | ng Physician: Mer this certifica meral director, p | To Be | examiner? 1 Yes 2 No 27. Manne of Death 1 Knatural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | Other | 1□ Yes 2 V | No 1 □ Yes 2 □ No a 6 □ Other (Specify) |
| n of | ng Physician: Mer this certifica meral director, p | Certification: To Be | examiner? 1 Yes 2 No 27 Manne of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined | 28a. Date of injury At home, fabuilding, etc. (Specify) | utpatient 3 DOA Other: 4 Nursing Time of Injury at Work? M 1 Yes 2 No arm, street, factory, office | ath Check on one Home 5 Residence 28d. Describe how i | |
| n of | ng Physician: Mer this certifica meral director, p | edicai Certification: To Be | examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 2 Madical Exam | 28a. Date of injury (Month, Day Year) 28b. 28e. Place of Injury - At home, fabuilding, etc. (Specify) | tipatient 3 □ DOA Other: 4 □ Nursing Time of Injury 4 Work? M 28c. Injury at Work? 1 □ Yes 2 □ No | 1 Yes 2 Neath Check only one Home 5 Residence 28d. Describe how i | 1 Yes 2 No 1 Yes 2 No 3 6 Other (Specify) Injury occurred t and Number or Rural Route Number, tate) |
| n of | tending Physician: leath. tor: After this certifica the funeral director, p | Certification: To Be | examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Check only 2 Madical Exam | 28a. Date of injury 28b. 28a. Place of Injury - At home, fabuilding, etc. (Specify) 28b. Place of Injury - At home, fabuilding, etc. (Specify) | utpatient 3 DOA Other: 4 Nursing Time of Injury at Work? M 1 Yes 2 No arm, street, factory, office | 1 Yes 2 Neath Check only one Home 5 Residence 28d. Describe how i 28f. Location (Stree City or Town, Street at the time, date | 1 Yes 2 No a 6 Other (Specify) njury occurred t and Number or Rural Route Number, late) e(s) and manner as stated, and place, and due to the cause(s) Date signed (Month, Day, Year) |
| n of | ng Physician: Mer this certifica meral director, p | edicai Certification: To Be | examiner? 1 | 28a. Date of injury (Month, Day Year) 28a. Place of Injury - At home, fabuilding, etc. (Specify) 28ician: To the best of my knowledginer: On the basis of examination ar and manner stated. | utpatient 3 DOA Other: 4 Nursing Time of Injury A Work? M 28c. Injury at Work? 1 Yes 2 No arm, street, factory, office a, death occurred at the time, date and pla ad/or investigation, in my opinion, death oc 29c. License number 29c. License number | ath Check on one Home 5 Residence 28d. Describe how in 28f. Location (Stree, City or Town, Stree, and due to the cause curred at the time, date | And I Yes 2 No a 6 Other (Specify) Injury occurred It and Number or Rural Route Number, late) a(s) and manner as stated, and place, and due to the cause(s) Date signed (Month, Day, Year) |

| | | - State Unpend Item 2 | State of Ma 3a,27,28a- | ryland/ f per | Depa me | artment of He 1850 12-7- 1111cate of L | ealth and 05 tas eath | Mental Hy | gierze Reg. No. | 005 | 38170 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------|--------------------------|--------------------------------------------------------------|---------------------------------------------|-----------------------------------------|--------------------------------------|----------------------------------------------------|----------------------------------------------------------|
| Physicia /Medic | | Decedent's Name (First, Middle, Last Dorothy |) J | • | | Cromwell | | 2. Date of De Month Novemb | Day | 2, 2005 | 3. Time of Death 1:01 A M |
| Examin | | 4a. Facility Name (If not institution, give | ospital | | | 4b. City, Town, or Baltin | ore | | 4c. (| County of Death | |
| Funeral Director | | 5. Social Security Number 6. Si 218-64-1787 1 Usual Residence of Decedent | TM 200E | (In yrs. last b | Yrs. | If Under 1 Year Months Days | If Under 24 H Hours Mi | | h V. <i>Year)</i> 3–56 | 9. Birth Cou | place (State or Foreign ntry) Md. |
| the Maryland 28e-f ehow | tor | 10a. State 10b. County Md . NA | | 10c. City, To | wn or Lo | | | | | | 10d. Inside City Limits XXYes 2 ☐ No |
| th with the 23a or 28 | al Director | 10e. Street and Number 2133 E. Chase St | reet | | | 10f. Zip Code 2121. | 3 | | 10g. Citiz | en of What Cou USA | ntry? |
| U36 urs after dea al', or iteme | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💆 N If Yes, Give Year or Dates: | | 1 | Was Decedent of His fYes, specify Cuban 1 □ Yes 2√2 No | spanic Origin? , Mexican, Pu Specify: | (Specify Yes or No erto Rican, etc.) | | 4. Race - Ameri Black, White Specify: B] | |
| re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural; or Iteme 23s or 28e-f ehow other traumatic event, the Medical Examination matched | Completed | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) | | | (Give life. | dent's Usual Occupation of work done du DO NOT use retired) | tion uring most of w | rorking | | d of Business/Ir | |
| land Z ld be filed ental Hygi ked other ic event, the | To Be Co | UNKN 17. Father's Name (First, Middle, Last) Donald | | Cromw | | | | ame (First, Middle, | Maiden S | ver Wor Sumame) nn | Jackson |
| Maryla ind 2 should lath and Men 27 is marke | - | 19a. Informant's Name/Relationship (7 Wally Cromwell | ype, Print) Son | 19 | | ng Address (Street ar | nd Number or | Rural Route Numbe | er, City or | Town, State, Zij | |
| Baltimore, Ma permit. Pages 1 and 2: Depertment of Health at Important: If item 27 is eny injury or other trea | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | cemet | of Dispo | sition (Name of natory or other place |) | Date -30-05 | 20c. Loc | ation - City or T | |
| Balt permit. Depertr Imports eny Injorts | | 21. Signature of Funeral Service Licen | Wane | | 22 | . Name and Address March F. | | Balti 110 | more, | | 21202 |
| 876(cate be physicia the bur | edical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Narcotic Due to (or as a Due to (or as a d. | consequence | of): | toxication | | | | | |
| Attending Physician: The law requires that the death certific redeath. etter: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as it | by Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 1 9 □ Unknown | 2 🗌 Fetal deat | | Ectopic pregnancy Other (specify) | | | 23 | 3d. Date of deliv Month | ery Day Year |
| w requires that been signed t | ted by P | Part II. Other significant conditions of | ontributing to death bu | it not resulting | in the u | nderlying cause giver | n in Part I. | 23e. Did to | 2 | , | he cause of death? pably 4 □Unknown |
| I VIII RECOFGS, yeician: The law requires the secretificate has been signedirector, page 2 should be of | e Completed | 25. Was case referred to medical | | | | | | 1/2 Yes | sy med? 2 \(\sum \text{No} \) | 24b. Were auto prior to co death? 1XX Yes | ppsy findings available impletion of cause of 2 No |
| Physicia this certi | To Be | examiner? | Hospital: 1 🗌 Inpatier | nt 2 ERVC | utpatien | t 3 DOA Other | - | eath (Check only of Home 5 Resid | | Other (Special | (y) |
| To the Hospital or Attending Phy within 24 hours eller death. To the Euneral Director: After this completely filled in by the funeral d | Certification; | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | 28a. Date of Injury Found: Day 11-22-05 | Year) For 12: | Time of 1710 : 45 | A M 1 □ Y | at ? es 2 1X No | 28d. Describe h | | | unk |
| To the Hospital or Attence within 24 hours eiter death To the Funeral Director: completely filled in by the | | 4 Homicide determined | 28e. Place of Injubuilding, etc. Found: R vsician: To the best of | . (Specify) esidenc | ce | | data and ala | Baltimor | e Ci | ty, Mar | |
| Lothe Hospital within 24 hours (To the Funeral completely filled | Medical | (Check only 2 Medical Examone) 29b. Signature and fittle of certifier | iner: On the basis of and manner star | examination a | nd/or in | estigation, in my opi | nion, death oc | curred at the time, o | date and p | signed (Month, | the cause(s) |
| F S F ŏ | | 30. Name and address of person who | ompleted cause of de | eath (Item 23a) | (Type | | O.C.M.E | | | mber 23, | |
| Sta | te. | S. P. Hay A 31. Date filed (Month, Day, Year) | NU | | | n Street, | Balti | more, Mar | yland | d 21201 | |
| Registra | | NOV 2 9 2005 | Marie | K | fore | 6 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere O. O. E.

| | | | 1 - For State Registrar | State of Maryla | | rtificate of L | | | ene 0 0 5 | 38171 |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------|----------------------------------------|---------------------------------------|--------------------------------------------------|----------------------------------------------------|
| | Physici /Medio | | 1. Decedent's Name (First, Middle, DOROTHY E. | COWANS | | | | 2. Date of Death Month 11 - 23 - | ^{Day} 2005 Year | 3. Time of Death 9:00 A M |
|) | Examir | er | 4a. Facility Name (If not institution, g | | CME C | 4b. City, Town, or | Location of Dear | h | 4c. County of Death |) |
| Ī | Funeral Director | | 5. Social Security Number 6 218 · 22 · 4118 | | s. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | | | place (State or Foreign of try) |
| | yland now | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | City, Town or Lo | ocation | | | 1 | 0d. Inside City Limits |
| | death with the Maryland ms 23a or 28a-f ehow rinual be dediffed at | Director | | imore gi | NUN | OAK | | | | 1 ☐ Yes 2 💯 No |
| | 3a or 2 | 2 | 10e. Street and Number 4601 BELLVIEW | AVENUE | | 10f. Zip Code 2120 | 7 | 109 | g. Citizen of What Cour | ntry? |
| | tems 2 | Funeral | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U.S. 13, V | Was Decedent of His If Yes, specify Cubar | | Specify Yes or No- to Rican, etc.) | 14. Race - Americ Black, White, | |
| 2-0030 | 2 hours after death with the Marylan atural', or Items 23a or 28a-f ehow igal Examilian must be inclified at | þ | 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced | I ☐ Yes 2 🗖 No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 /区 No | Specify: | | Specify: BLA | |
| <u>0</u> | "natural", | leted | 15. Decedent's (Specify only highest) | Education grade completed) | (Give | dent's Usual Occupa kind of work done di DO NOT use retired) | uring most of wo | rking 16 | 6b. Kind of Business/Ind | |
| 7 7 | d within 72 giene. or then "net | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | CU310 | , | | 9 | OCIAL SET | IRITY |
| and | d be file ntal Hy ed oth | Be | 17. Father's Name (First, Middle, La | | | | _ | me (First, Middle, Ma | | |
| ary | nit. Pages 1 and 2 should artment of Health and Mer ortent: If Item 27 ie marke injury or other treumatic 8. | P. | WILLIAM BILLUP 19a. Informant's Name/Relationship | - | 19b. Mailin | | | JIXON ural Route Number, (| City or Town, State, Zip | Code) |
| e, | s 1 and 2 f Health is from 27 fr | | GEORGE DIXON | (SON) | 411 1- | ALLWICOD | RD., C | MONSVILLI | | 28 |
| | Pages 1 nent of H int: If ite iry or ot | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | Removal from State | cemetery, cren | sition (Name of natory or other place | ′ I | | oc. Location - City or To | |
| Бант | permit. Pages Department of Importent: If I eny Injury or once. | | 21. Si in ture o Funera Selvice Lo | 1 see | RRISON 22 | FOREST Name and Address | | 2.05 O) JERAL SERVIC | NINGS MIU | IS, MD |
| L L | 40 E 5 8 | | 23a. Part . Enter the disease, or co | mplications that caused the dea | 5)5 | I BALLO NA | T PIKE E | SAUTO. MD 2 | 21229 | A |
| | Enysician | | Immediate Cause (Final disease or condition | ly one cause on each line. | CLER | / |) | BPO VAS | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a conse | quence of): | | | | | |
| | ם פ | Iner | Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying | b. Due to (or as a surrasquence of). | | | | | | |
| | execute and al-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as a conse | consequence of): | | | | | |
| 00/00 | tificate be executed g physicien and as the burial-transit | edical E | | d | | | | | | |
| | certific Iding p | 900 | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregr | nancy | _ | | | 22d Date of dollars | |
| 0.00 | sician: The law requires that the death cert certificate hes been signed by the attendin rector, page 2 should be detached for use | Physician/N | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown | al death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of delive Month | ry Day Year |
| <u>ທ</u> ູ | res that igned by be deta | by | Part II. Other significant conditions | contributing to death but not re | sulting in the un | nderlying cause giver | n in Part I. | | cco use contribute to th | |
| cords, | w requi | leted | | | | | | | - | ably 4 Donknown |
| ב ב | The lay ete hes page 2 | Completed | | | | | | 24a. Was an autopsy performe | prior to con death? | osy findings available inpletion of cause of |
| <u> </u> | ician: certific rector, | Be | 25. Was case referred to medical examiner? | Hospital: | | Other | / | th Check only one | | |
| 5 | g Phys terthis neral dii | n: To | 1 Yes 2 No 27. Manper of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 1 3L DOA | 4 Nursing H | ome 5 Residence 28d. Describe how | e 6 Other (Specify injury occurred |) |
| 2 | ttendin death. tor: Af the fur | catic | Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not | on be One Blass of talls | | M 1 🗆 Y | es 2 No | | | |
| <u>></u> | al or A s after al Direct | Certification: | 4 Homicide determine | d 28e. Place of Injury - At I building, etc. (Special | nome, farm, stre ify) | et, factory, office | | City or Town, S | et and Number or Rurai State) | Route Number, |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the tuneral director, page | Medical (| 29a. Certifier Check only 2 Medical Expone) | Physician: To the best of my kn aminer: On the basis of examin and manner stated. | owledge, death ation and/or inv | occurred at the time restigation, in my opi | e, date and place inion, death occu | , and due to the caus | se(s) and manner as sta and place, and due to | ated. the cause(s) |
| | To the within To the Comple | Me | 29b. Signature and title of certifier | / ^ | | 29c. License | number | 29d | . Date signed (Month, D | Day, Year) |
| | . 1 | | Jasuel | Valllia | m. | 12 | 18595 | _ 1 | 1/28/03- | |
| | 4 | | 30. Name and address of person wh | o completed cause of death (Ite | m 23a) (Туре, F , 72 22 | Print) PARK | HERC | - 1 | E DAY | Mi) 2/208 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. sistrar's Sign | ature | ast, | | | | |

State of Maryland / Department of Health and Mental Hygier 0051 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hovember 23 d COLE **Physician** VALLACE Year SV 8,20AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 10-22-20 Birthplace (State or Foreign Country) **Funeral** 215-18-3937 XXM 2□F 85 Director Yrs. MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic svent, the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö 1100 Penn Avenue Apt. 1503 21201 U.S.A. or Itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. e filad within 72 hours after of Hygiene.

Other than "netural", or Ital tXXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No þ Specify: Black 3XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3rd Technician Self Employed 17. Father's Name (First, Middle, Last) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If teen 27 Is marked oth any july or other traumatic svent soice. 18. Mother's Name (First, Middle, Be Harry Cole Susie Howard 19a. Informant's Name/Relationship (Type, Print) (daughte) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Susan R. Armstrong 4020 Carthage Rd. Randallsown, MD 21123 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 11-30-05 OwingsMills, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a Service Usinsee 22. Name and Address of Facility Wesley Chavis Jr. FH 2007 Eastern Ave. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one/gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final C'ARCINOMA Physician OF POROSTATE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Month 4□Pregnant at time of death 5 Other (specify) P.O. I ed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed baen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? The 2 | No 1 ☐ Yes 2 (No 1 Yas Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 ☐ Ne 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 10 Hovember 231d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hughtal Center Kangarajay 18Wthert Ha maswams State 9 Sauce Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First) 2. Date of Death 3. Time of Death 9:20AM Year 2005 aron 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ugle Road H:11 Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 10 M 2 F 411 218-92-7006 Yrs. MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Tes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hill Koad USA 2122 110 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) et Care Elementary/Secondary (0-12) Asst. St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. of St. 121 Asst 17. Father's Name (First, Middle, Last) D. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hillugle Rd Balto MD ZIZZ9 wife 110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11-28-05 Sykesuille, MO akeview Cemeter ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address a acility Va ugh n Coverne funeral Sevila 21. Signature of Funeral Service 8728 Libert Randellstown MD 21183 23a. Part1. Enter the disease, or complications that saysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brachaeure Due to (or as a consequence of): CERCINOMA disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Metostatu Diseau 1 Yes 2 No 3 Probably 4 ☐ Unknown portension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yper lipedemia 2**27** No 1 ☐ Yes 2**X** No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X esidence 6 Other (Specify) 2**)**⊈ № 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or othar traum once.

Physician

/Medical

Examiner

Director

by Funerai

Completed

Be

Funeral

Director

27 is markad other than "natural", or itams 23a or 28a-f ahow traumatic evant, the Mcdical Exorninar must be notified at

the Maryland

72 hours after

d 2 should be filed within 7. h and Mental Hygiene. 7 is marked other than "ns

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Examine Physician/Medicai þ ted Comple

executed use as the burial-transit certificate be attending phy: the þ ate has been signed page 2 should be det director this funeral Certification: After Hospital or Attanding after death. within 24 hours a To the Funeral D cai

IF FEMALE:

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

PIKEVILLE MD

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier myal fador

5 Pending

MD

Injury

29d. Date signed (Month, Day, Year) 23/05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SADOVNIK MIGVEL 1838 GREEN TREE Rel.

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year D. Campbell Theodore 12:30 AM 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care Homewood Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 12-29 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 **XM** 2 □ F MD 218.05.0912 87 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or Items 23 cor 28a-f show ont: If item 27 Is marked other then "naturel", or Items 23c or 28a-f show 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Madical Examiner must be notified at Baltimore 1 Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4904 Greenspring 21209 Avenue Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 P⊈Yes 2 □ No 1 □ Never Married 2 □ Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: þ 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Securiti Suponisor 12th grade 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Campbell Carrie Gran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 Is. any injury or other treu once. L. Thomas/Grandson 9520 Lyon Wood Drive Owing Mills MD 2117
Date Or Disposition (Name of Date 2) Location - City or Town, State Chevell 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition 1 Sourial 2 Cremation 3 Removal from State 12-05-05 OWING MILD, MD 4 ☐ Donation 5 ☐ Other (Specify) Garnson Forest 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Talling C. Greene Funeral Services
6151 Baltimbre National Pike Balto MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician Colon Cancer WITH Metasters disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): burialphysician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertersia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypercholestrolenic 2 No 1 Yes director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 1 (DNatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical within 24 hc To the Fun completely (Check only one) and manner stated.

State Registrar 29b. Signature and the of certifier

31. Date filed (Month, Day, Year) ROV 2 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Salvic

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

6821

29c. License number

Restors town Rd

D0059656

29d. Date signed (Month, Day, Year)

BEH MO 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [2] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day AVEU Brema 11-23 7:00 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LORIEN FRANKFORD NIA BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 04. | 19. | 19.5 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F 219 52 9953 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ir than "natural", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at NA 1 Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 703 NORTH PAYSON STREET 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. I □ Yes 2 12 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced ie markad othar than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) ADMINISTRATIVE SUPERVISOR 12 TH GRADE MD. DISTRICT COURT NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental H MATHEW CAREY GEORGEANNA TABB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 ie
eny injury or other trau JEROME A. SCOTT SON) ST., BALTO. MD 703 N. PAYSON 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) GREENMOUNT 21. Signature of Funeral Service I hansee 11.29.05 BALTIMORE 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATC. PIKE, BALTO MI) 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** endocarditis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical as attending p IF FFMALE 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached o 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 melli tus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed VAScular diseas E 24b. Were autopsy findings available prior to completion of cause of death? nnera 24a. Was an has autopsy performed? certificete t ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital : After this certific tuneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Anatural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: , 3 🗌 Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 5 To the Hospital within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35102 November 28 vally on ma person who completed cause of death (ttem 23a) (Type, Print) north CUAYLES Street Baltimore 5901

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (M

strar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year der Nov 2005 /Medical Jawn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frankford horien 7. Age (In yrs) last birthday) N/A rear If Under 24 Hrs. f Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Months Days Hours Min. Yrs. Director 49 212-70-8623 OCT 8 1956 MISSOURI Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 No BALTIMORE 28a-f MARYLAND N/ADirect 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or **APT 105** 3633 GREENMOUNT AVE 21218 U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 10 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other then. Elementary/Secondary (0-12) College (1-4or 5+) BUS/TRACTOR TRAILOR DRIVER TRANSPORTATION 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental h unknown EXTRA FORD POWELL CAROLYN POWELL and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Charles E. Crider/Husband 3633 Greenmount Ave., Apt 105, Baltimore, Md. 21218 Baltimore. 20a. Method of Disposition
1 ⊞Buriai 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 7 permit. Page Department of Importent: If any injury or once. *4 □ Donation 5 □ Other (Specify) ARBUTUS MEMORIAL 11-28-05 BALTIMORE, MARYLAND 21. Signature of Foreral Service Livensee WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physicien Physician/Medical the IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy for 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Yes 2 No 3 Probably 4 Wiknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending 5 Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MD21222 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygieria] () 5 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 2005 Carroll 12:25a^M Regina /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel
If Under 1 Year | If Under 24 Hrs. | Laurel Regional Hospital 8. Date of Birth (Month, Day, 09 20 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 T F Hours Min 101 Yrs. Director 1904 Μ̈́D 215-64-4573 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c, City, Town or Location "natural", or Itams 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 U.S.A. 7314 Fairbrook Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Black 3 XWidowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ve filad within 7. at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 7th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 Is markad oth Be 2 <u>Martha</u> Johnson Charles Henry Chew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Md 20794 Pearl Vaughn-Daughter 8173 Hick Road, Jessup, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Department or Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 11/28/05 Elkridge, Md Meadow Ridge 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Cerebral Thrombosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrilation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be exacuted nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for L 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year Month 4 Pregnant at time of death 5 Other (specify) P.O. been signad by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 No 2 No 1 Yes 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 1 Xinpatient ို 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours after To the Funaral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William A. Warren 321 Prince George St, Laurel, Md 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

| | | | For State | State of Maryland / | | | ental Hygien | ከበ5 : | 38178 |
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| | | | Registrar 1. Decedent's Name (First, Middle, Las. | *) | Certificate of I | | Reg. N 2. Date of Death | | 3 Time of Death |
| | Physici /Medi | | Scott Ray | Cantrel | '/ | | Month D | 3 05 | 3. Time of Death 9:53 A M |
| 1 | Examir | ner | 4a. Facility Name (If not institution, give Baltimore Washi) | 19ton Medical (| tr Gler | Durme | / | c. County of Death | inde-1 |
| * | Funeral Director | | 5. Social Security Number 6. Se 317-90-0371 Usual Residence of Decedent | 7. Age (In yrs. last I | birthday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Yea. 10/29/7 | 9. Birth Cou | place (State or Foreign intry) |
| | e Maryland a-f ehow | ctor | 10a. State 10b. County | undel 10c. City, To | Men Burr | nie | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | ath with th | Funeral Director | 10e. Street and Number Notti | ngham Dr. | 10f. Zip Code | 21061 | 10g. C | itizen of What Cou | ntry? |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Itema 23a or 28a-1 ehow important: if Item 27 is marked other then "naturel", or Itema 23a or 28a-1 ehow appring or other traumatic event, the Medical Examinar must be notified at ADGE. | by Fune | 11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No | ispanic Origin? (Spec an, Mexican, Puerto R Specify: | ify Yes or No- ican, etc.) | 14. Race - Ameri Black, White, Specify: (U) | |
| 15-0036 | "nature | eted | 15. Decedent's Edi (Specify only highest grad | Ication 16 completed) | Sa. Decedent's Usual Occupa (Give kind of work done of | during most of working | 16b. | Kind of Business/In | ndustry |
| 2121 | filed within Hygiene. Ither then " | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | Dog Gr | roomer | D | log Gro | omer |
| /land | should be file and Mental Hy marked oth umatic event | To Be | 17. Father's Name (First, Middle, Last) | ay Cantrell | 3 | Sheila | First, Middle, Maide | n Sumame) La Fo | 19e |
| Mary | nd 2 sho lith and 27 is ma r trauma | | 19a. Informant's Name/Relationship (7) | (Antrell-father | 9b. Mailing Address (Street a | 1 | Route Number, City | or Town, State, Zip | nd 21061 |
| lore, | Pages 1 and nent of Health int: if item 27 iry or other tr | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I | Removal from State 20b. Place | of Disposition (Name of tery) crematory or other place | Da | 1 /8: | Location - City or To | |
| Baltimore | permit. Pag Department Important: I any injury o | | 4 □Donation 5 □Other (Specify, 21. Signature of Funeral Service □cons | 10.10.1 | 22. Name and Address | notion 128 | rgieton F | uneral | Home P.A. |
| | 20 E 2 3 | | 23a. Part1. Enter the disease, or comp | Way WOI3(0 lications that caused the death. D | not enter the mode of dying | Ave SW g, such as cardiac or | respiratory arrest, | Burnie | Mc 21061 |
| | Physician /Medical | | shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) | 1 | ardiac am | est | | | Interval Between Onset and Death IMME AIGHE |
| ₩., | Examiner | 10 | Sequentially list conditions, | b. tansplant Due to (or as a consequence | + vascalo | nathij | | | years |
| | acuted nd transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | cardiac + | -mas plan | tation | , | | |
| 8760, | cate be executed only sician and the burial-transit | Icai | resulting in death) Last | d. <u>Cardio myo</u> | | | | | |
| P.O. Box 6 | ath certifii Itending p or use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown | | | | 23d. Date of delive Month | ery Day Year |
| | quires that the de in signed by the a uld be detached f | þ | Part II. Other significant conditions co | ntributing to death but not resulting | g in the underlying cause give | en in Part I. | 23e. Did tobacco | use contribute to the | |
| I Records, | The law require ate has been si page 2 should I | Completed | | | | | 24a. Was an autopsy performed? | death? | opsy findings available impletion of cause of |
| Vital | ician: Th certificate rector, pag | Be (| 25. Was case referred to medical examiner? | | | 26. Place of Death (| | | |
| of | ding Physician: The h. After this certificate hit funeral director, page | on: To | 1 ☐ Yes 2 ② No 27. Manner of Death 1 ☐ Matural 5 ☐ Pending | | Outpatient 3 DOA Cthe Outpatient 3 DOA Cthe Outpatient 28c. Injury Work | 4 Nuising Home | e 5 Residence d. Describe how inju | | (y) |
| Division | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home, building, etc. (Specify) | | Yes 2 □No | f. Location (Street a City or Town, Stat | nd Number or Rura | al Route Number, |
| L. | To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the | | Check only Z Medical Exam | sician: To the best of my knowled ner: On the basis of examination a | ge, death occurred at the time | ne, date and place, an | d due to the cause(s | s) and manner as s | stated. |
| | To the within 2 To the complet | Medicai | one) 29b. Signature and title of certifier | and manner stated. | 29c. License | number | 29d. Da | ate signed (Month, | |
| , | ~ | | I tople Golden | TIMP | | 36885 | / | 11/23/05 | |
| i | 1 | | 30. Name and address of person who co | ib, ad Gre | ene St. I | Baltimo | re, M | d | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | 1 Sperlie | | | | |

State of Maryland / Department of Health and Mental Hygie 2e 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOV. **Physician** Bobby Ray Chesney, Sr. 2:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month. Day. Year) 1975 5. Social Security Number 556-48-9300 Funeral 9. Birthplace (State or Foreign 1 ☑-M 2 ☐ F Country) Arkansas Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Carroll 1 ☐ Yes 2 ☐ No Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4359 Downhill Trail 21074 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give: 1956 Year br Dates: 1956 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Machinist Western Industrial 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth ery lipiny or other traumatic event 90R. 18. Mother's Name (First, Middle, Maiden Sumame) Daniel William Chesney Hecie Bell Brixey ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Chesney - wife 4359 Downhill Trail, Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Hov. 30, 2005 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Md. Dulaney Valley Nem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chapel P.A. 21. Signature of Funeral Service Licensee 3296 Charmil Dr. Manchester, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adenorationa months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. ian/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year Physici 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď disesse 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe No. Division of Vital 1 🗌 Yes 1 Yes Hospital or Attending Physicien: 25. Was case referred to medicat Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence Oxfother (Specify) HOSP CE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) é 4 Homicide the Certifying Physician: To the best of my knowled je, death commend at the time, date and plane and the talk of the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier pletely i (Check only one) 29b. Signature and title of certifier 2 29c, License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) N Charles St -cultures MD/6601 31. Date filed (Month, Day, Year) 2. Registrar's Signature 9 2005 Registrar

November 27, 2003

Selbu (Herrey

| | | | 1- State of Maryla | nd / Depa <i>Cei</i> | artment of Health and tificate of Death | | giene 0 0 1 | 38180 |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------|-------------------------|-----------------------|-----------------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | | 2. Date of De | ath | 3. Time of Death |
| н | Physici /Medic | | Matilde Arambula Carrera | | | Novembe | er 16, 20 | 05 10:20A ^M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location of E | Death | 4c. County of | |
| | | | 4908 Butternut Drive | | Rockville | | Montgo | mery |
| | Funeral | | 1 N 207 C | . last birthday) | If Under 1 Year If Under 24 Months Days Hours | Min. (Month, Da | th y, Year) 9 | . Birthplace (State or Foreign Country) |
| | Director | | 424-44-5964 69 Usual Residence of Decedent | Yrs. | | July 27 | , 1936 | Colombia |
| | and | | | ity, Town or Lo | cation | | | 10d. Inside City Limits |
| | Mary | ō | N1 N | | | | | 1 ☐ Yes 2 🖾 No |
| | the roll | Directo | Maryland Montgomery Ro | ckvill | 10f. Zip Code | | 10g. Citizen of Wha | at Country? |
| | 3a ol | | 4908 Butternut Drive | | 20853 | | | • |
| | me 2 | Funerai | 11. Marital Status 12. Was Decedent Ever in U | J.S. 13.1 | Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, P | ? (Specify Yes or No | United S | American Indian, |
| 9 | filed within 72 hours after death with the Maryland Hyglene. ther than "naturel", or Iteme 23a or 28a-f show that the Medical Evaninar must be redified at | | Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No | | | olombian | | White, etc. |
| 5-0036 | ours | d by | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: | | 1⊠Yes 2□No <i>Specity:</i> C | olombian | Specify: | wnite |
| ر م | 72 h 'natu | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced | lent's Usual Occupation kind of work done during most of DO NOT use retired) | f workina | 16b. Kind of Busin | ess/Industry |
| 121 | vithin ne. han | шb | Elementary/Secondary (0-12) College (1-4or 5+) | | | | | |
| 2 | Hygie Hygie ther t | ပ္ပ | 12 17. Father's Name (First, Middle, Last) | Assist | ant Manager | Name (First Adiable | Accountin | ng |
| au | e d all all all all all all all all all a | Be | | | | Name (First, Middle, | Maiden Sumame) | |
| Maryland 21 | d 2 should be filed within 72 hours after death with the Marylan th and Mental Hyglene. 7 Ie merked other than "naturel", or Iteme 23e or 28e-f show traumatic event, the Medical Examinational be notified at | 2 | Luis Alfonso Arambula 19a. Informant's Name/Relationship (Type, Print) | 19b Mailir | Julla g Address (Street and Number of | Mendez | or City or Town Sta | ato Zio Codo) |
| <u>8</u> | | | Victor B. Carrera / Husband | | Butternut Drive | | | |
| <u>ق</u> | 一工 る 幸 | | 20a. Method of Disposition 20b. | Place of Dispo | sition (Name of | Date | 20c. Location - Cit | |
| Ê | Pages nent of int: If it iry or o | | 1 🖾 Burial 2 □ Cremation 3 □ Removal from State Ga '4 □ Donation 5 □ Other (Specify) | te of 1 | 1041011 | vember , 2005 | Cilron Cm | wing Mountland |
| altimore, | permit. Page Department of Important: If any injury or once. | | 21. Signature of Fune al Service Licensee | | Name and Address of Facility Dert A. Pumphre | | | ring,Maryland |
| m | | | Jun Denfundo | | OWest Montgomer | | | |
| п | | | 23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. | | er the mode of dying, such as car | rdiac or respiratory ar | rest, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or conditiona_ Glioblaston | na Mult | iforme | | | Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a conse | | <u> </u> | | | |
| н | Lxammer | er | Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse | | | | | |
| | ted nsit | nine | cause. Enter Underlying Cause (Disease or injury | quence on): | | | | |
| <u>,</u> | execun and ial-tra | Examin | that initiated events c | quence of): | | | | _ |
| 68760 | ificate be executed g physician and as the burial-transit | edicai | | | | | | |
| _ | ** D d | ledi | | | | | | |
| Вох | death certiff e attending id for use as | an/h | IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 1□Live birth 2□Fet | | Ectopic pregnancy | | 23d. Date o | |
| | 0 0 0 | Physician/M | 1 ☐ Yes 2 ☒No 4 ☐ Pregnant at time of | | Other (specify) | | Month | Day Year |
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| | res that signed to be det | ρλ | Part II. Other significant conditions contributing to death but not re | sulting in the ui | iderlying cause given in Part I. | | | te to the cause of death? |
| 0 | w requir been si should I | eted | | | | _ ' ' ' | es 2 No 3 | Probably 4 \(\text{\text{Unknown}}\) |
| Vital Records, | The law requires that the sate has been signed by the page 2 should be detache | Completed | | | | — 24a. Was | sy prio | e autopsy findings available to completion of cause of |
| <u>=</u> | | | | | | 1 🗆 Yes | rmed? deat 2⊠No 1□ | Yes 2□No |
| \rightarrow | sicien: certific rector. | o Be | 25. Was case referred to medical examiner? Hospital: | | 0.11 | Death (Check only o | | |
| ö | Phys r this oral dir | - | 1 ☐ Yes 2 ☑ No ☐ 105pital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury | ER/Outpatien 28b. Time of | 4 JUNUISI | ng Home 5 A Resid | lence 6 Other (| Specify) |
| o | th. : After s funer | tior | 1 XNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation | Injury | 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | | own, any occurred | |
| Division of | or Attend after death Director: | ifica | 3 Suicide 6 Could not be determined 28e. Place of Injury - At h | nome, farm, str | eet, factory, office | 28f. Location (S | Street and Number o | or Rural Route Number, |
| ā | s after al Dire | Certification; | 4 Homicide Standard building, etc. (Special | ny) | | City or Tow | m, State) | |
| | Hospitel or Attending Physicien: 24 hours after death. Funeral Director: After this certificietly filled in by the funeral director. | | 29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examin | owledge, death | occurred at the time, date and p | lace, and due to the | cause(s) and manne | er as stated, |
| | To the Hos within 24 ho To the Func completely f | Medical | one) and manner stated. 29b. Signature and title of certifier | | 29c. License number | | | |
| | 1 × 1 8 | | | | | | 29d. Date signed (N | |
| i | 12 | / | 30. Name and address of person who completed cause of death (Ite | m 23a) /Tune | M D06033J | | November | 17,2005 |
| 0 | | | Paul Bannen 1811 Prince | DK: / | Dalve # 372 | Olac A | 10 208 | 52 |
| | Sta | te | 31. Date filed (Month, Day, Year) 32 Registrar's Sign | ature | N. | J. 11-41 | U and | |
| | Registr | ar | NOV 2 9 2005 | B BO | Prive #327 | | | |

| | | | For State Registrar | State of M | larylan | d / Depa <i>Cei</i> | artment of H tificate of L | ealth D <i>eath</i> | and Me | | giepe Reg. No. | 005 | 3818 | 3 |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------|----------------------------------|------------------------------------------------|--------------------------|----------------------------------|---------------------------------------|------------------------|-------------------------------------------------|---------------------------------------------|------------|
| | Dhaminia | | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. | Date of De. | | Year | 3. Time of | Death |
| н | Physicia /Medic | | Shun-Cheung 1 | W. Chin | | | | | N | ovembe | | | 5:40 | АМ |
| | Examin | | 4a. Facility Name (If not institution, give | | ") | | 4b. City, Town, or | | of Death | | | County of Deat | | |
| | | | Rockville Nursing | | // | 1- a4 6 a6 d- 1 | Rockvi If Under 1 Year | | er 24 Hrs. g | Data of Bird | | ontgome | | . 5 |
| | Funeral Director | | 5. Social Security Number 6. S 031-42-0747 | .ex 1□M 2∏XF /.A | 84 | last birthday) Yrs. | Months Days | Hours | Min. A | Date of Birt (Month, Da pril 20 | y, Year) 192 | 1 Hong | hplace (State o untry) g Kong | r r-oreign |
| | | - | Usual Residence of Decedent | | | | | l | A | prii 20 | , 172 | .I IIOII | Kong | |
| | yland | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | 10d. Inside Ci | |
| | a-fs | cto | Maryland Montgon | nery | Roc | kville | | | | | | | 1 X Yes | 2 🗌 No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citiz | en of What Co | untry? | |
| | ath w 23e | la l | 303 Adclare Road | | | | 20850 | | | | | ed Sta | | |
| | er de | une | 11. Marital Status | 12. Was Deceden | ? | | Was Decedent of Hi f Yes, specify Cuba | ispanic O n, Mexica | rigin? (Specif an, Puerto Ric | 'y Yes or No can, etc.) | - 1 | Race - Ame Black, White | | |
| 36 | rs afte | by Funeral | 1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X If Yes, Give Year or Dates | | | 1□Yes 2XNo | Specify | y: | | | Specify: [| Asian | |
| 8 | thou | ed | 15. Decedent's E | | | 16a. Dece | dent's Usual Occupa | ation | | | 16b. Kin | d of Business/ | Industry | |
| 75 | nin 72 | Completed | (Specify only highest gr Elementary/Secondary (0-12) | ade completed) College (1-40) | 54) | (Give | kind of work done o DO NOT use retired | durina mo | st of working | | | | | |
| 21, | d with | mo | Clementary/Secondary (0°12) | 2 | 3+) | Ва | ank Telle | r | | | В | anking | | |
| 밀 | al Hy al Hy I oth | Be (| 17. Father's Name (First, Middle, Last | ") | | | | | her's Name (F | | Maiden S | Sumame) | | |
| <u>X</u> | Ments Ments arkec | 2 | Wai Pak Wong | | | | | | an Su | | | | | |
| a | 2 sho | | 19a. Informant's Name/Relationship | | | 7 | ng Address (Street a | | | | - | | (ip Code) | |
| d) | l and lealth im 27 har t | 1 | Christina Chen/ | daugnter | 20h F | | Furber La: sition (Name of | ne, | rramın; | | | 01701 ation - City or | Town State | |
| ğ | iges or of | | 1 X Burial 2 ☐ Cremation 3 | | ө С | emetery, crer | natory or other plac | 1 | Novemb | er | | | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23e or 28e-f show any injury or other traumetic event, The Neulcal Exameter into the Invitibial at once. | 1 | * 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice | | For | | ls Cemeter | | 28, 20 | | | | sachus | |
| Ba | perm Depa Impo any i | | I Hulliam a. Hun | phren | | | Name and Address bert A. Pu 57 Wiscons | | | | | hesda-Che yland | evy Chase 20814 | e, Inc. |
| Г | | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | plication that cause one cause on each | ed the deat line. | h. Do not ent | er the mode of dyin | g, such a | is cardiac or re | espiratory a | rest, | | Approximate Interval Bett Onset and I | ween |
| 4 | Pnysician | 8 | Immediate Cause (Final disease or condition resulting in death) | a | | cy Fail | Lure | | | | | | | |
| | /Medical Examiner | | resulting in death) | Due to (or a | | uence of): | | | | | | | | |
| | T TIME | - | Sequentially list conditions, | b. Demen | | uence of): | | | | | | | | - |
| | nsit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | thyro | | | | | | | | | |
| , | execun and ial-tra | Exal | that initiated events resulting in death) Last | Due to (or a | | | | | | | | | | |
| 8760, | icate be executed physician and s the burial-transit | dical | (| d | | | | | | | | | | |
| 9 | tifical ng phy as th | led | 15.551111.5 | | | | | | | | | | | |
| Вох | death certific e attending p od for use as 1 | by Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom 1☐Live birth | | | Ectopic pregnancy | | | | 2: | 3d. Date of deli Month | | r'ear |
| О. П | 0 0 2 | sici | in the past 12 months? 1 ☐ Yes 2 ☒ No | 4□Pregnant 9□Unknown | | | Other (specify) | | | | - W | MONTH | Day | i eai |
| <u>P</u> | that the de led by the a detached f | Phy | 9 ☐ Unknown Part II. Other significant conditions | contributing to death | but not rec | ulting in the u | adarhina sausa au | on in Bod | | 23e Did t | nhacco us | e contribute to | the cause of d | leath? |
| ds, | Se La | d by | Part II. Other significant conditions | contributing to death | Dut not res | | nderlying cause give | bii ii r ait | | | | | obably 4 X) | |
| Vital Record | w requires been significations | Completed | | | | | | | | 24a. Was | an | 24b. Were au | topsy findings | available |
| æ | The law ate has page 2 | mo | | · | | | | | | | rmed? 2 X No | death? | completion of ca 2 No | ause of |
| ta | | 0 | 25. Was case referred to medical | | | | | 26. Plac | ce of Death (0 | | | | | |
| { | Physician: this certific | To B | examiner? 1 ☐ Yes 2X No | Hospital: 1 Inpa | tient 2 | ER/Outpatier | nt 3□ DOA Othe | er: 4XIN | Nursing Home | 5 □ Resi | dence 6 | Other (Spec | cify) | |
| n of | | | 27. Manner of Death 1 X Natural 5 ☐ Pending | 28a. Date of In (Month, D | ijury Day Year) | 28b. Time of Injury | Worl | k? | | d. Describe I | now injury | occurred | | |
| Sio | Attanding or death. actor: After by the fune | catl | 2 Accident investigation 3 Suicide 6 Could not I | 20 | | | | Yes 2 | | | 244 | t blomber on De | | L |
| Division | or At fter o | Certification: | 4 Homicide determined | 280. Place of I | njury - At h etc. <i>(Specil</i> | ome, farm, str y) | eet, factory, office | | 281 | City or To | | i Number or Hu | ıral Route Num | ber, |
| | To the Hospitel within 24 hours a To the Funeral I completely filled | edical C | 29a. Certifier 1 Certifying P (Check only one) | hysician: To the bes miner: On the basis and manner: | of examina | owledge, deat ation and/or in | n occurred at the time vestigation, in my o | ne, date a pinion, de | and place, and eath occurred | d due to the at the time, | cause(s) a date and | and manner as place, and due | stated. to the cause(s | i) |
| | To th withir To th comp | Me | 29b. Signature and title of certifier | | 0 | | 29c. License | e number | r | | 29d. Date | signed (Montl | h, Day, Year) | |
| | | 1 | - Inoun | 0 U - 1 | 1000 | 111 | D00 | 4733 | 0 | | Nove | mber 22 | 2, 2005 | |
| (| | | 30. Name and address of person who Thomas V. Josep | completed cause of | | | Print) | e, #: | 207, R | ockvi] | le, | Marylan | nd 208. | 52 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 9 200 | 2. Regis | strar's Signa | ature | | | | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 05 38 | 82

| | | • | 1 - Stete Registrar | , | Ce | rtificate of L | Death | | Reg. N | .000 | 30102 |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|------------------------------|-------------------------|-------------------------------|--------------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, I | .ast) | | | | 2. Date of D | | ay Yea | 3. Time of Death |
| | Physicia /Medic | | LILLI | AN HOLGATE CR | EECY | | | NOV | 22 | 2005 | 11:14 A M |
| | Examin | _ | 4a. Facility Name (If not institution, g | | | | Location of Death | | 4 | c. County of De | |
| | | 专 | NATIONAL NAVAL | | | BETI If Under 1 Year | HESDA If Under 24 Hrs. | 8. Date of Bi | 45 | MONTG | |
| \$ | Funeral Director | | , | 1 □ M 2 1 X F | vrs. last birthday) OF Yrs. | Months Days | Hours Min. | (Month, D | ay, Yea | r) (| irthplace (State or Foreign Country) |
| -2. | | | 507-60-6631 Usual Residence of Decedent | | 85 | | | May 23 | 1 L | 920 Ca | anada |
| | ehow | | 10a. State 10b. County | 10c. | City, Town or Lo | ocation | | | | | 10d. Inside City Limits |
| | e Marie | ctor | Virginia | V: | irginia | Beach | | | | | 1 Yes 2 No |
| | or 26 | Funeral Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. C | citizen of What (| Country? |
| | ath w | rai | 138 Pinewood Ro | | | 23451 | | | | ted Sta | tes |
| | ltems | une | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | 12. Was Decedent Ever in Armed Forces? | n U.S. 13. | Was Decedent of Hill If Yes, specify Cuba | ispanic Origin? (Sp in, Mexican, Puerto | Rican, etc.) | 0- | Black, Wi | |
| 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 26a-f ehow or other treumatic event, the Madical Examitment must be multified at | by F | 3 ☑ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 😾 No | Specify: | | | Specify: | hite |
| Š | 2 hou | ted | 15. Decedent's | | 16a. Dece | dent's Usual Occupa | ation | (100 | 16b. | Kind of Busines | |
| 215 | thin 7 | Completed | (Specify only highest Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired | l) | ang | | | |
| | 12 should be filed within h and Mental Hygiene. 7 is marked other than "Ireumatic event, the Mes | Con | | 4 | Homen | naker | | (5) | | wn Home | |
| Maryland | be fit d oth | Be | 17. Father's Name (First, Middle, La | st) | | | 18. Mother's Nam | | e, Maide | en Sumame) | |
| Ya | ould I Men narke vatic | To | George Holgate | (T = 0 : 1) | 105 14-7 | | Annie T | | 0.1 | T Ct-1- | 7-0-4-1 |
| Mai | 12 st h and 7 is n treun | | 19a. Informant's Name/Relationship | | | ng Address (Street : | | | | | |
| Ġ, | 1 and Healt em 2 ther | | Robert H. Creecy 20a Method of Disposition | | b. Place of Dispo | osition (Name of | | Pt. Wa | | .ngton . Location - City o | MD 20744 or Town, State |
| Baltimore, | ages int of t: if it | | 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | □Removal from State M | cemetery, crea iontgome | matory or other plac ピソ | Nove | | Pot | thoado | Marriand |
| Ħ | ertme ortan Injury | | 21. Signature of Funeral Service Lie | | 2: | ium, Inc. 2. Name and Addres | ss of Facility RC | bert A | . Pu | mphrey | Maryland Funeral Home, |
| B | permit. Pages 1 and 2:3 Depertment of Health at Important: If Item 27 is any Injury or other treu QDGE. | | 3 insola | MO MO | Be | ethesda-Cl ethesda, l | nevy Chas | e, Inc. 20814- | . 75 | 57 Wisc | onsin Avenue |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List or | omplications that caused the o | | | | | | | Approximate Interval Between |
| | Physician | | tmmediate Cause (Final disease or condition | | TT CVCTT | M ODCAN I | 7 A TT 11DE | | | | Onset and Death |
| 2. | /Medical | | resulting in death) | a | | M ORGAN I | ALLUKE | | | | |
| п | Examiner | | Sequentially list conditions | 0. | DIOMYOPA | THY | | | | | |
| | pe is | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) | Due to (or as a con | sequence of): | | | | | | |
| | and I-tran | хаш | that initiated events resulting in death) Last | c Due to (or as a con | sequence of): | | | | | | |
| 68760, | eath certificate be executed attending physicien and for use as the burial-transit | | | | , | | | | | | |
| 587 | ficate phys | Medical | (6) | d | | | | | | | |
| Box (| nding use a | - | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pre | | 7= | | | | 23d. Date of c | lelivery |
| | requires thet the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit | by Physician | in the past 12 months? 1 ☐ Yes 2X No | 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time | | ⊒Ectopic pregnancy ⊒ Othe <i>r (specify)</i> | | | | Month | Day Year |
| P.O. | thet the de ed by the a detached f | hys | 9 ☐ Unknown | 9□ Unknown | | | | | | | |
| | signed I | by | Part II. Other significant condition | s contributing to death but not | resulting in the u | inderlying cause give | en in Part I. | | | | to the cause of death? |
| ord | w require been si | ted | | | | | | 11 | Yes | 2 <u>M</u> No 3 | Probably 4 Unknown |
| ec | - Ω 70 | Completed | | | | | | 24a. Wa auto | s an opsy formed? | prior t | autopsy findings available o completion of cause of |
| al F | : The law cate has | | | | | | | 1 ☐ Yes | 2 X N | | es 2□ No |
| Vit | Phyeician: Th this certificate al director, pag | Be | 25. Was case referred to medical examiner? | Hospital: 1 X Inpatient | | ot 3 DOA Oth | 26. Place of Dea | | | | |
| ō | Phys r this ral di | 1: To | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury (Month, Day Yea | 2 ER/Outpatie | 11 30 DOX | 4 Ituraling in | ome 5 ☐ Res 28d. Describe | - | 6 ☐Other (S) jury occurred | овсту) |
| On | ding th: Afte fune | itio | 1 XNatural 5 ☐ Pending 2 ☐ Accident investiga | | r) Injury | | k? Yes 2 □ No | | | | |
| Division of Vital Records, | Atter r dea ector by the | Ifica | 3 Suicide 6 Could no 4 Homicide determin | t be 28e. Place of Injury - / | At home, farm, st | reet, factory, office | | 28f. Location City or To | | | Rural Route Number, |
| Ö | s afte el Dir ed in | Certification: | 4 E Homedo | building, etc. (Sp | ochy) | | | Only or 11 | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, | edical | | Physicien: To the best of my caminer: On the basis of exam | | | | | | | |
| | the H | Medi | one) | and manner stated. | | 29c. Licens | | | | Date signed (Mo | |
| | To Too | | 29b. Signature and title of certifier | huellas | | 01010 | | , | | 0VZ3 | |
| | 1/1 | 1 | 20 News and | no completed cause of death | (Itom 22a) (T | | | | | | |
| Î | 0 | | 30. Name and address of person w | | (Item 23a) (Type: ISA | IVAL | 'IONAL NA' 'HESDA MD | | | | ₹ |
| | Sta | ate | DAVID CHANDLES 31. Date filed (Month, Day, Year) | 32 Aegistrar's S | | DEI | TITODA MID | 20009- | אטטנ | J | |
| 18 | Regist | | NOV 2 9 | 2005 Brave | N 19 | - C C C C C C C C C C C C C C C C C C C C C C C C C C C C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C - C | | | | | |

| | | | 1 - State Registrar | | Cer | tificate of | Death | | Reg. No. | | |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------|------------------------------------------------|---------------------------------------|-------------------------------------------|-----------------------|------------------------------------------|----------------------------------|
| 3 | y * * | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of De | | Vone | 3. Time of Death |
| | Physici /Medic | | BARBARA | DIGGS | | | | NOVE | 1BER | 25 2005 | 1612 M |
| | Examin | | 4a. Facility Name (If not institution, give st | reet and number) | | 4b. City, Town, o | r Location of Dea | ath | 4c. C | ounty of Death | |
| | | | MONTGOMERY GENE | RAL HOSPLTA | L | OLNE | 1 1 | 4MAIL | M | ONTGO | MERY |
| | Funeral | (GC) | 5. Social Security Number 6. Sex | 7. Age (In yrs. | | If Under 1 Year Months Days | If Under 24 Hr Hours Mir | s. 8. Date of Bir (Month, D | th w, Year) | 9. Birthp Cour | place (State or Foreign htry) |
| See. | Director | | 214-28-4010 | 64 | Yrs. | | | Month D. 5-2. | 3-41 | | MD |
| | and * | | Usual Residence of Decedent 10a, State 10b, County | 10c. Cit | y, Town or Lo | cation | | | · | 1 | Od. Inside City Limits |
| | anyli eho | ō | M | 77 | altin | | | | | | 1 Yes 2 □ No |
| | 28a- | ect | 10e. Street and Number | | activity. | 10f, Zip Code | | | 10a, Citize | on of What Cour | ntrv? |
| | with the or | ă | | Street | | 212 | 30 | | 1 | 154 | |
| | ris 23 | era | 1820 Spence | 2. Was Decedent Ever in U. | .S. 13. V | Vas Decedent of H | lispanic Origin? (| Specify Yes or No |)- 14 | Race - Americ | |
| (O | riter | Funeral Director | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 No | | Yes, specify Cuba | | erto Rican, etc.) | | Black, White, | etc. |
| Ö | ai', o | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 1 | ☐ Yes 2 No | Specify: | | S | specify: Wh | ite |
| 21215-0036 | within 72 hours after deeth with the Maryland ene. then "natural", or items 23a or 28a-f ehow he Medical Examiner must be notified at | Completed | 15. Decedent's Educi (Specify only highest grade | | (Give | lent's Usual Occup | during most of w | orking | 16b. Kind | d of Business/In- | dustry |
| 21 | ithin Jen. | mpi | Elementary/Sec indary (0-12) | College (1-4or 5+) | life. L | OO NOT use retired | d) | | T | ·~ | 1. |
| | led w lygier her tl | | 17. Father's Name (First, Middle, Sast) | | | mesti | 19 Mothar's N | ame (First, Middle | Maiden S | orriesa | ٦_ |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at ODGe. | Be | Malilia T Di | aas | | | 1 1 - 1 | aide | 1 | 115 | |
| Ž | hould d Me mark matic | 은 | 19a Informant's Name/Relationship (7) | ala nt) | 19b. Mailin | q Address (Street | | | | | Code) |
| <u>≅</u> | id 2 s lith an 27 io trau | | Venin Truin / 8 | Son | 11221 | Kacha | Hill C | +. Suite | 102 6 | Janton 1 | /A 2019 |
| စ် | Heal Heal tem | | 20a. Method of Disposition | 20b. F | | sition (Name of | | Date | 20c. Loca | ation - City or To | own, State |
| OL | ages ant of nt: ff i | | 1 ☐ Burial 2 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | moval from State | | out Cent | 12 | 11/05 | R | Homore | mo |
| altimore, | ortar injur | | 21. Signature of Funeral Service License | G, | 22 | Name and Addre | s F cilite | witces, | | 11.11.101 | |
| ä | Depa Impo eny ir | | Cuaho () | 10020 | 51 | 51 Ballo | | Ke Balt | ה יווי היוואלצייל | - mb | 21229 |
| - 70 | Y | | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one | ations that caused the deat | | | | | | - | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | PNEUL | ALKON | | | | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a conseq | | 1 | | | | | 1 0000 |
| | Examiner | | Sequentially list conditions, b. | HYPER | CAPNE | EIA | | | | | IWEEK |
| 7 | D = | iner | if any, leading to immediate | Due to (or as a conseq | | | | | | | 1 |
| v | ertificate be executed ding physicien and se as the burial-transit | Examiner | Cause (Disease or injury that initiated events c. resulting in death) Last | AZOTE | , , | | | | | | IMEEK |
| 90 | e execien a | | tesuring in death, cast | Due to (or as a conseq | | BREAST | - NIONE | DIACM | | | 4 |
| 68760, | cate t | Medical | d. | INCE INS | A | DELIS | 14601 | 0/21/1 | | - | THINOM 9 |
| 9 x | ding i | /Me | IF FEMALE: | c. If yes, outcome of pregna | ancy | | | | - | and Danie of Marking | |
| Bo | attene for us | ian | in the past 12 months? | 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d | il déath 3 □ | Ectopic pregnancy Other (specify) | y | | 23 | d. Date of delive Month | ery Day Year |
| P.O. | the de | Physician | 1 ☐ Yes 2 ØNo 9 ☐ Unknown | 9□ Unknown | 50 | Cities (specify) | · · · · · · · · · · · · · · · · · · · | | | | |
| | Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burai-transit | 4 7 | Part II. Other significant conditions cont | ributing to death but not res | ulting in the ur | nderlying cause giv | ven in Part I. | 23e. Did | obacco use | e contribute to the | he cause of death? |
| ds | quires n sign ald be | d by | | | | | | 10 | Yes 2□ | No 3 Prob | pably 4 Unknown |
| S | w requires been signatured is | Completed | | | | | | 24a. Was | | 24b. Were auto | ppsy findings available |
| Re | The la | E G | | | | | | auto perf | ormed? | prior to co death? 1 \(\sum \) Yes | mpletion of cause of |
| ta | an: tifica tor. p | Be C | 25. Was case referred to medical | | - | | 26. Place of D | eath Check only | - 100 | 1 🗆 103 | 2010 |
| > | ysici | To | examiner? 1 □ Yes 2 ☒ No | ospital: 1 Inpatient 2 | ER/Outpatien | t 3 DOA Ott | ner: 4 🗆 Nursing | Home 5□Res | dence 6 | Other (Specif | ·ý) |
| 0 | ng Ph ter th neral | | 27. Manner of Death 1 SNatural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of | 28c. Injur Wor | y at rk? | 28d. Describe | how injury | occurred | |
| Ö | Attending in death. | atic | 2 Accident investigation | | | | Yes 2 □No | | | | |
| Division of Vital Records, | r Att | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At he building, etc. (Specif | ome, farm, str fy) | eet, factory, office | | 28f. Location City or To | Street and wn, State) | Number or Rura | al Route Number, |
| | urs af rei D | | | | | | | | | | |
| | To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2. | edical | 29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin | ician: To the best of my kno er: On the basis of examina and manner stated. | owledge, death ation and/or inv | n occurred at the till vestigation, in my c | me, date and pla opinion, death oc | ce, and due to the curred at the time, | date and p | nd manner as s lace, and due to | tated. o the cause(s) |
| | thin 2 the the imple | Med | 29b. Signature and title of certifier | and manner stated. | | 29c. Licens | se number | 1 | 29d. Date | signed (Month, | Dav. Year) |
| 1 | F 3 F 8 | | 000 | ATTENDING PH | Nercia | | 2656 | | | | |
| | 1 | | 30. Name and address of person who cor | | • | | 10/0 | | 40 OFY | MDCK (| 26,2005 |
| | 9 | | SUNIA HOLMES M. | D. (BID! PRIM | ICE PHIL | IP DAVE | DINE | 1 MARNI | ALM | 2083 | 2 |
| | Sta | ate | 31 Date filed (Month Day Vens) | 22 Pagietere's Sign | ature | | 1 -11-1 | 1 10 1 15 | w ∀ 11 [| , 0.) | |
| | Regist | rar | NOV 2 9 2005 | Brown K | Brech | 9 | | | | | |
| DH | IMH 17 Rev 1/2 | 001 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:15 PM Nov. 22 2005 Richard Cornelius Donkervoet /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Cockeysville Broadmead 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1₩ 2□F Oct. 8 1930 Michigan Director 370-26-4564 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28e-f show other traumstic event, I'm Medical Examinar must be mathed at 1 ☐ Yes 2 ☐ No Directo MD Cockeysville **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 USA 13801 York Rd. M12 by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1X1Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Commercial d Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Architect 5+ 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Eva Hendrika Boer Cornelius Donkervoet ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1114 Walnut Wood Rd., Hunt Valley, MD 21030 Sharon D. Credit/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Defation 5 ☐ Other (Specify) 11/25/05 Catonsville, MD McNabb Crematory 21. Styletti, of Fluy rai Selve (Libers 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Bryan W Clary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical nsequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as earliers.) Due to (or as a consequence of Examine certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year The law requires that the death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 2/ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 🗌 Yes 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne - Jeath Certification: After Injury atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title 0 and address of person who completed cause of death (Item 23a) (Type, Print 101 BROADMEAD. SANZAKO 31. Date filed (Month, Day, Year) 32. Registras s Signature State

DHMH 17 Rev 1/2001

Registrar

| | | - | For State Registrar | State | of Mary | | partmer ertificat | | | and Me | ental Hyg | iene | 005 | 38185 |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------|-----------------------------------|-----------------------------------------------|------------------------------------------------|-----------------------------------------------|----------------|----------------------------------------------|-----------------|----------------------------------------|---------------------------------------------------|
| | Physicia | an | Decedent's Name (First, Middle ELYANA PAO | | B DAYST | 'AR | | | | | 2. Date of Deat Month NOV 2 | Day | 005 Year | 3. Time of Death 10:55 A M |
| | /Medic Examin | | 4a. Facility Name (If not institution, NATIONAL NAVAL | , give street and | number) | | | Town, or | Location o | f Death | | | County of Dea | ath |
| | Funeral Director | | 5. Social Security Number NOT AVAILABLE | 6. Sex 1 ☐ M 2 🖔 | 7. Age (In | yrs. last birthd | Months | Days 6 | If Under a | Min. | 8. Date of Birth (Month, Day, VOVEMBER | Year) | | rthplace (State or Foreign ountry) MARYLAND |
| | faryland show | 'n | Usual Residence of Decedent 10a. State 10b. County | | 100 | c. City, Town or | | IA CILTI | иотом | . D. (| 2 | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| | or 28e-f | Director | 10e. Street and Number | | | | | Code | NGTON | , D.C | | 0g. Citiz | zen of What C | country? |
| 036 | 72 hours after death with the Maryland naturel; or Items 23a or 28e-f show alcal Exemple from the fieldlind at | by Funeral | 1400 20TH 11. Marital Status 1 ☒ Never Married 2 ☐ Marria 3 ☐ Widowed 4 ☐ Divorced | 12. Was I Armed | N.W. # Decedent Ever d Forces? Yes 2 No i, Give or Dates: | | 3. Was Dece If Yes, spe 1 \(\text{Yes} | - 25 | 2003 spanic Orig n, Mexican Specify: | | city Yes or No- lican, etc.) | | 14. Race - Am Black, Wh Specify: | |
| 21215-0036 | filed within 72 hor Hygiene ther then "nature int, the Mudical | Completed | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | it grade complet | ted) ge (1-4or 5+) | 16a. De (G | ecedent's Usu ive kind of w e. DO NOT u | ial Occupa ork done d ise retired; NO | uring most | t of workin | g | 16b. Kii | nd of Busines | s/Industry |
| Maryland 2 | e d la b | Be | 17. Father's Name (First, Middle, | Last) AARON BA | ATLEY-D | ΔΥςτΔρ | | | | | (First, Middle, M | | Sumame) | |
| lary | 2 should be and Menta is marked aumatic ev | 은 | 19a. Informant's Name/Relationsh | | | 19b. M | | | | or Or Aural | Route Number | City o | Town, State, | Zip Code) |
| altimore, N | Pages 1 and 2 should ment of Health and Mer ant: if item 27 is marke ury or other traumatic | | JACOB AARON BAILE 20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (S) | 3 □Removal fr | rom State | 0b. Place of Di | sposition (Na crematory or MEMOR | me of other place | ARK | NOVE 28 | MBER 2005 | 20c. Lo RO(| cation - City o | E, MARYLAND |
| Balt | permit. Page Depertment: Important: if eny injury o | | 21. Signature of Funeral Service 23a. Part1. Enter the disease, or |) Kinge | | 0335 I | ETHES SETHES | DA-CH DA, M | EVY (| CHASE AND 2 | INC. 0814-35 | 755: 01 | REY FU | JNERAL HOME/ DNSIN AVENUE |
| 8760, | Physician /Medical Examiner but side policy of the policy fransit street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but street but | edical Examiner | shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, tary, leading 15 mmodiae cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b | on each line. | E PREMA | ATURIT | | | | | | | Interval Between Onset and Death |
| O. Box 6 | at the death certifica by the ettending phached for use as the | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 1□L 4□P | s, outcome of pr ive birth 2 — Pregnant at time Inknown | Fetal death | 3 □Ectopic p 5 □ Other (s | | | | | 2 | 23d. Date of de Month | elivery Day Year |
| ۵. | fuires that I n signed by Ild be deta | ğ | Part II. Other significant condition | ms contributing | to death but no | ot resulting in th | e underlying | cause give | en in Part I. | | | oacco u es 2 | | to the cause of death? Probably 4 Unknown |
| Records, | Physicien: The law requires that the this certificate hes been signed by the ral director, page 2 should be detache | Completed | | | | | | | | | 24a. Was a autops perform | ned? | prior to death? | autopsy findings available completion of cause of |
| Vital | sicien: The certificate he rector, page | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Othe Othe | NE | | (Check only on | Θ) | <u> </u> | |
| Division of Vital | ding After fune | tion: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig | 28a. D | 1 🔯 Inpatient Date of Injury Month, Day Ye | | | 28c. Injury Work | 4 140 | 2 | ne 5 ☐ Reside 8d. Describe ho | | | ecify) |
| Divisi | or A ufter Direction by | Certification: | 3 Suicide 6 Could determ | ined 200. F | Place of Injury - ouilding, etc. (S | At home, farm Specify) | , street, facto | ry, office | | 2 | 8f. Location (St City or Town | | | Rural Route Number, |
| | To the Hospital within 24 hours a To the Funeral I completely filled | edicai | (Check only 2 Medical one) | and | o the best of m the basis of exa manner stated. | y knowledge, d amination and/o | or investigation | n, in my op | oinion, dea | d place, a | ed at the time, d | ate and | place, and du | ie to the cause(s) |
| | To the vithin 2 To the complet | Σ | 29b. Signature and title of certifie | 1 | // | 40 | | a. License | | /T7A | | . / | | 2005 |
| 1 | 17 | | 30. Name and address of person | who completed | cause of death | (Item 23a) (Ty | | | 34561 ONAL | | L MEDIC | | | 2005 |
| ر |) Sta | to | CHRISTINE AUNE 31. Date filed (Month, Day, Year) | | MC USA Registrar's | Sign a ture | 1.11. | BETH | ESDA | MD . | 20853-8 | 990 | | |
| | Regist | | NOV 2 9 | 2005 | BRUSI | 15. P | ball | | | | | | | |

Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit 6849 11-29-05 TT Amend item#20a-c, perFit

| | | Certificate of Death | Reg. No. 38186 |
|---------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| | Distriction | 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year 3. Time of Death |
| | Physician */Medical | CHESCETTIETO DOWNS | November 6 Zeos 7:00 AM |
| 1 | Examiner | Tall admity Hallie (if not institution, give street and number) | , or Location of Death 4c. County of Deeth |
| | | Annapolis Nursing & Rehab Anna 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24. | polis Anne Arundel Hrs. 8 Date of Birth 9 Righblace (State or Foreign |
| e. | Funeral Director | 219-16-1542 1 Months Days Hours M | Hrs. 8. Date of Birth (Month, Day, Year) Dec 5 1925 Maryland |
| | arytend show del | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits 172 Yes 2 □ No |
| | 28a-f | Maryland Anne Arundel Annapolis | 10g. Citizen of What Country? |
| | ifter death with the Ma r items 23a or 28a-f s ricer must be notified | 100. Street and Number 101. Zip Code 1909 E. Copeland St. 21401 | USA |
| 020 | urs e | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | 14. Race - American Indian, Black, White, etc. Specify: Black |
| Maryland 21215-0020 | ed within 72 hor ygiene. ter than "nature it, if o Medical E | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th 0 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Construction | f working 16b. Kind of Business/Industry Reliable Contractor |
| 9 | Hygir officer ont, | | Name (First, Middle, Maiden Surname) |
| lan | s marked offi s marked offi sumatic ever | George Downs Marth | ha Isaac |
| ary | 2 shou and M is mar reumat | | or Rural Route Number, City or Town, State, Zip Code) |
| | Health a tem 27 ls | Geraldine Parker(Daughter) 1909 E. Copeland | St. Annapolis, Md. 21401 |
| Baltimore, | permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr pnce. | 20a. Method of Disposition **XX**Burial 2-\$\frac{1}{2}\text{Cremation} 3 \square Removal from State} 4 \square Donation 5 \square Other (Specify) 20b. Place of Disposition (Name of More Place) **More Place of Disposition (Name of More Place) **More Place of Disposition (Name of More Place) | Date Crownsville, MD 11/29/05 Baltimore, Md. |
| Balti | permit. Pages of Department of Haportant: If Ite any injury or of once. | | ons Mortuary, P.A. |
| | | 23a. Part1. Enter the illsease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. | Annapolis, Md. 21401 rdiac or respiratory arrest, Approximate |
| | Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. JSTRIC CSULUMON. Due to (or as a consequence of): | Onset and Death |
| 68760 , < | ificate be executed g physician and as the burial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated ever it. | |
| | - O 0 - | | |
| Box | attendin Ifor use | | 23b. Did tobacco use contribute to the cause of death? |
| P.0. | that the death cer ed by the attendin detached for use | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown |
| Records, | requires | | 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? |
| Re | sicien: The law r certificate hes b lirector, page 2 st | | 1 ☐ Yes 2 █ No 1 ☐ Yes 2 ☐ No |
| Vital | entificat ector, p | | f Death (Check only one) |
| > | Physiclen: this certific ral director, | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | ing Home 5 ☐ Residence 6 ☐ Other (Specify) |
| on of | Attending Ph or death. ector: After th by the funeral | | 28d. Describe how injury occurred |
| Division | tal or Attending Presents death. el Director: After ted in by the funera | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | | 29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated. | and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s) |
| | within To the compl | 29b. Signature and title of certifier 29c. License number | 29d. Date signed (Month, Day, Year) |
| | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | 2 November 7 2005 regled Hyattsv. He MD 20781 |
| | タナー | PAN A DEUSCE MS +203 QUENSBUN | regRed Hyattsv. 1/e MD 20781 |
| 47 | State Registra | 2005 | • |

| | | | For State Registrar | | State | of Maryla | ind / Depa <i>Ce</i> | artme <i>rtifica</i> | nt of H <i>te of l</i> | lealth a Death | and Me | | giene Reg. No | C. 101 | 38 | 3187 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------|----------------------------------------|-------------------------------|-------------------------------------|---------------------------|--------------------------|---------------------------|-------------------|---------------|------------------------------|-------------------------|----------------------|-------------------|----------------------------|
| 1 | Dhusisi | 38 | 1. Decedent's Name | | | | | | | | 2 | 2. Date of De | ath Da | y Year | | Time of Death |
| *** | Physici /Medic | | Krystyna | Anna Ed | lmondson | | | , | | | | 11 | 2: | | | 7:50 P ^M |
| | Examin | | 4a. Facility Name (/ | f not institution, g | rive street and no | umber) | | 4b. City | , Town, or | r Location of | of Death | | 4c | . County of Dea | ath | |
| | | - | Suburban | | | | | | hesd | | 2211 | | | ontgome | | |
| ** | Funeral | | 5. Social Security N | | .Sex 1□M 2√5√F | | s. /ast birthday) Yrs. | Months | or 1 Year Days | If Under Hours | Min. | B. Date of Bir (Month, Da | ıy, Year) | 0 | ountry) | (State or Foreign |
| | Director | | 579-74-7 Usual Residence of | | 7127 | 71 | 113. | | | | | 1-8-19 | 134 | Po1 | and | |
| | land ow | | 10a. State | 10b. County | | 10c. | City, Town or Lo | ocation | | | | | | | 10d. I | nside City Limits |
| | Mary -f sh | ţ | n/a | n/a | | Dis | strict (| of Co | lumb: | ia | | | | | 24 | Yes 2□No |
| | r 28a | Director | 10e. Street and Nu | mber | | | | 10f. Z | ip Code | | | | 10g. Cit | izen of What C | ountry? | |
| | 72 hours after death with the Maryland natural', or Nems 23s or 28s-f show deat Examinal must be motified at | D | 3911 Leg | ation St | ., NW | | | 20 | 015 | | | | USA | | | |
| | death | Funerai | 11. Marital Status | | 12. Was Dec | cedent Ever in | U.S. 13. | Was Dec | edent of H | ispanic Ori | igin? (Spec | ify Yes or No |)- | 14. Race - Am | | ndian, |
| 9 | or Ite | | 1 Never Marr | ied 2√ Married | Armed F 1 Tes If Yes, G | 2 No | | ıı res, sp 1 □ Yes | | Specify: | i, Puello Ri | ican, etc.) | | Black, Whi | | |
| 8 | iral', | d by | 3 Widowed | 4 Divorced | Year or I | Dates: | | | 252110 | Specify. | | | | Specify: WII | TLE | |
| 5 | be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or items 23a or 28a-f show other, the Madical Examinat must be notified at | Completed | (Spec | 15. Decedent's cify only highest of | |) | 16a. Dece (Give | kind of w | ork done o | during mos | t of working | 7 | 16b. K | ind of Business | /Industr | У |
| 12 | within iene. • than | mpi | Elementary/Seco | ondary (0-12) | - | (1-4or 5+) | | | use retired | , | · . | | 0 1 | C 17 1 | 1 | |
| 7 | filed y Hygie ther i | | 17. Father's Name | (First Middle La | 5 + | | Artis | E/II. | ustr | | | : T First, Middle | | E-Emplo | yea | |
| ano | d be findal l | Be c | Mieczys1 | | | | | | | | | rzewsł | | ournamo, | | |
| 2 | should be ind Mental marked o umatic eve | 은 | 19a. Informant's Na | | | | 19b. Maili | na Addres | ss (Street a | and Numbe | ar or Rural I | Route Numb | er City o | or Town, State, | Zin Coo | de) |
| Maryland 21215-0036 | and 2 sealth an n 27 is. | | John Edm | | | | A | - | | | | | | OC 2001 | , | , |
| 5 | 一工多章 | 103 | 20a. Method of Disp | | | 20b | . Place of Dispo | osition (Na | ame of | 201 | Da | te | 20c. Lo | ocation - City or | r Town, | State |
| Baltimore, | Pages nent of int: If It iry or o | | | | | State C | nesapea! | ke Cı | remat | ory 1 | 1-26- | 2005 | Be1 | tsville | , MI |) |
| Ħ | 글 된 본 글 . | | 21. Signature of Fu | | | | 22 | 2. Name a | and Addres | ss of Facilit | y Silv | er Spi | ing | MD 209 | 10 | |
| m | Depa Depa Impo eny i | | | - | 7 | ma135 | D. | app I | uner | al & | Crema | tion S | Serv: | ices 93 | 3 Gi | lst Ave. |
| * | 4. | | 23a. Part1. Enter t | he disease, or co | mplications that | caused the de | ath. Do not en | ter the mo | de of dyin | g, such as | cardiac or | respiratory a | rrest, | | App | proximate ervai Between |
| | Physician | | fmmediate Cause disease or condition | (Final | , | | EAST | CA | KER | | | | | | Ons | set and Death |
| | /Medical | | resulting in death) | - | Due to | (or as a cons | equence of): | | | | | | | | | |
| | Examiner | | Sequentially list co | anditions. | b | - | NINGI | TIS | | | | | | | | |
| | ם # | iner | if any, leading to in cause. Enter Unde Cause (Disease or | nmediate ertying | Due to | (or as a cons | equence of): | | | | | | | | | |
| | and trans | Examine | that initiated events resulting in death) | S | c | (or as a cons | oguesee of): | | | | | | | | - | |
| 60, | icate be executed physicien and s the burial-transit | a E | | | 03010 | (01 43 4 00113 | 54461106 31). | | | | | | | | | |
| 68760, | phys the | edical | | | d | | | | | | | | | 7 | | |
| | leath certific attending pl | | IF FEMALE: | | 23c. If yes, or | utcome of pred | nancy | | | | | | | 23d. Date of de | livon | |
| Вох | atter for u | ciar | 23b. Was deceden in the past 12 1 Yes 2 | months? | | birth 2 ☐ Fe nant at time o | | ∃Ectopic ∃ Other (s | pregnancy specify) | , | | | | Month | Day | Year |
| Q | The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a | Physician/M | 9 Unknown | | 9□ Unki | nown | | | | | | | | | | |
| ٦, | es that igned b | by P | Part II. Other signif | ficant condition: | contributing to | death but not r | esulting in the u | nderlying | cause give | en in Part I. | | 23e. Did t | obacco i | se contribute t | o the ca | use of death? |
| of Vital Records, | w require been sig should b | | | | | | | | | | | 10 | Yes 2 | □No 3□P | robably | 4 Unknown |
| ္မင္တ | law re | Completed | | | | | | | | | | 24a. Was | | 24b. Were a | utopsy f | indings available |
| Ä | The fate has page | E | | | | | | | | | | | rmed? 2 % LNo | | compie | tion of cause of |
| ital | ician: certifica ector, p | Bec | 25. Was case refer | red to medical | | | | | | 26. Place | of Death (| Check only o | | 1 | | |
| > | 8 S E | 70 E | examiner? 1 Tes 2 | -No | Hospitaf: | Inpatient 2 | ☐ ER/Outpatier | nt 3 🗆 🗅 | Othe Othe | er: 4 🗆 Nu | rsing Home | 5 ☐ Resi | dence | 6 □Other (Spe | ecify) | |
| | ding Ph h. After th funeral | 5 | 27. Manner of Deat | th 5 🗌 Pending | 28a. Date (Mo | of fnjury nth, Day Year) | 28b. Time o fnjury | f | 28c. Injury Work | y at k? | 28 | d. Describe I | how in j ui | y occurred | | |
| sio | or: | cati | 2 Accident 3 Suicide | investigat | be | | | М | | Yes 2 □ I | | | | | | |
| Division | | Certification: | 4 Homicide | determine | ad 286. Plac | e of Injury - At ding, etc. (Spe | home, farm, str cify) | eet, facto | ry, office | | 28 | City or To | Street an wn, State | id Number or R i) | u ra i Roi | ute Number, |
| | pital ours a oral (| | 29a, Certifier | red Cartifying | Physician: To th | o bost of my k | nowlodge does | h 000111110 | d at the tim | no data an | d slass as | d due to the | 201122/2 | and manager a | s state d | |
| | 24 ho Fun etely | Medical | (Check only one) | 2 Medical Ex | aminer: On the | basis of exami | nation and/or in | vestigatio | n, in my or | pinion, dea | th occurred | at the time, | date and | place, and du | e to the | cause(s) |
| | To the Hospital or within 24 hours aft To the Funeral DII completely filled in | Me | 29b. Signature and | title of certifier | | | | 2 | 9c. License | | | | | te signed (Mon | | |
| | 1 | | > 2 | 7 | | | | | H 50 | 128 | | | Nove | mBER 2 | 5,2 | 200 |
| | 10 | | 30. Name and addr | ress of person wh | no completed cau | use of death (I | em 23a) (Type, | Print) | | Α- | \ | | | | | |
| | ` | | | MORRISC | N, POF | ACP ! | em 23a) (Type, 5410 G | D. WILL | नाय | THUE | NW | WASH | 200 | UN X | - 20 | 00 |
| 1 | Sta Registr | | 31. Date filed (Mon | nth, Day, Year) V 2 9 20(| | Registrar's Sig | nature | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** RIVANNA 9: Vatim NOVEIMBER 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOURS BALTIMORE HOSPITAL NIA 30 N If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕱 F 2 12,1913 SouTH C 219-10-604 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at TIMORE 1⊠Yes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 VENUE 45A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specity: þ 3. Widowed 4 □ Divorced ACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9+HGRADE RAILROAD 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဂ္ THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I BALTO, MD. 21229 ENA FOSTER DAUGHTER AVENUE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State CEMETER 11-30-05 GLENBURNIE, * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses BROWN TR. FUNERAL HOME N. FULTON AVE. BALTO. conce 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT **Physician** 4 DAYS ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROTIC HEART ATSEASE UNENOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEURYSM, 1 ☐ Yes 2 ☐ No 3 🗍 Probably 4 Unknown Be Completed HYPOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 WNo 1 ☐ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☑Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 22 2008 D 23300 M-D. BON SELUNES 12 WESTITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEL, SUDKIR 2000W. BA2TO. 51. 13ALTU- MD. 31. Date filed (Month, Day, Year) NOV 2 9 2005 2. Registrar's Signature State Registrar

| Please Type or Print in Black Indelible Ink | . Ensure All Copies Are Legible. |
|---------------------------------------------|----------------------------------|
|---------------------------------------------|----------------------------------|

| | | | For State Registrar | Sta | ite of Man | yland / Depa <i>Cer</i> | irtment of H tificate of L | | ientai Hygier Reg. i | 4000 | 38189 |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------|------------------------------------------|----------------------------------------|-----------------------------------------|-------------------------------------------|--------------------------------------------|-------------------------------|--------------------------------------------------|
| ľ | Physicia | ₽ | 1. Decedent's Name (First | , Middle, Last) | | | | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | /Medic | al . | Calvin 4a. Facility Name (If not in | -416-41144 | and numbers | | Flic | ht Location of Death | November | 21 200 4c. County of Dea | |
| | Examin | er | VA Maryland | | | -em | Perry | | 1 | Cecil | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (/ | n yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Bir | thplace (State or Foreign |
| | Director | | 218-42-985 | | □ F 5 | 9 Yrs. | Months Days | Hours Min. | 06 30 | 46 | MD |
| | and | | Usual Residence of Deced 10a. State 10b. | dent County | 10 | 0c. City, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Maryl f sho | ţo | MD | NA | | Baltime | ore | | | | 1√2 Yes 2 □ No |
| | r 28a | Director | 10e. Street and Number | | | | 10f. Zip Code | | 10g. (| Citizen of What Co | ountry? |
| | 23£ o | | 2612 North | Charles | Stree | t | 2 | 1218 | | U.S.A | _ |
| | ar dea | Funerai | 11. Marital Status | 12. Wa | is Decedent Eve ned Forces? | er in U.S. 13. V | Vas Decedent of Hi Yes, specify Cuba | spanic Origin? (Spe n, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - Ame Black, Whit | erican Indian, |
| 50 | hours after death with the Maryland tural', or Itams 23c or 28a-f ehow at Examinat must be rivilitied at | by F | 1 Never Married 2 3 Widowed 4X D | 155 |]Yes 2 ☐ No 'es, Give ar or Dates: | 1 | ☐ Yes 2 No | Specify: | | Specify: | Black |
| Š | be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Itams 23s or 28a-f ehow event, the Medical Examinat must be multiped at | ted | 15. D | ecedent's Education highest grade comp | plata d) | 16a. Deced | ent's Usual Occupa | ation furing most of worki | 16b. | Kind of Business | |
| Z | within 72 ene. than "nai | Completed | Elementary/Secondary | | liege (1-4or 5+) | life. L | O NOT use retired |) | | | |
| 7 | filed w Hygier other th | | 12th grade 17. Father's Name (First, I | | ıa | Tri | ack Driv | | (First, Middle, Maid | elf Em | ployed |
| Maryland 21215-0036 | | o Be | | | C | | | | | | |
| 37 | s 1 and 2 should be f Health and Mental litem 27 is marked of other traumatic eve | ပို | Robert Lee 19a. Informant's Name/Re | | | 19b. Mailin | g Address (Street a | nd Number or Rum | ances Ba Il Route Number, Cit | y or Town, State, . | Zip Code) |
| | 5 # 7 F | | Paul Fligh | t-Brothe | r | l Ho | oi Court | , Randa | llstown | Md 2. | 1133 |
| ore | es 1 a of Hea if item or othe | | 20a. Method of Disposition | | | 20b. Place of Dispos cemetery, cren | sition (Name of natory or other plac | | Date 20c. | Location - City or | Town, State |
| Baltimore, | Pages tment of tant: If it | Н | 1 Burial 2 Cren 4 Donation 5 C | | | | | | 29/2005 E | Baltimo: | re, Md |
| ga | permit. Pages Department of I Important: If it any injury or o | | 21. Sign tark of Funeral S | Service Licensee | V. L | Ma | Name and Address | l West | | | |
| - | | | 23a. Part1; Enter the dise | ease, or complication | s that caused th | e death. Do not ente | | | Baltimo or respiratory arrest, | ore, Md | 21215 Approximate |
| | Physician | | Immediate Cause (Final | re. List only one cau | | | | - D' | | | Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | | | nodeficie | ency virus | s Disease | | | Unknown |
| | Examiner | | Sequentially list condition | s. b | | | | | | | |
| / | ed isit | ine | Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury | ite 🚽 | Due to (or as a c | consequence of): | | | | | |
| | and al-trar | Examiner | that initiated events resulting in death) Last | C | Due to (or as a c | onsequence of): | | | | | |
| 68760, | ificate be executed g physician and as the burial-transit | edicai | | | | | | | | | |
| _ | ± 50 € | Medi | IF FEMALE: | | | | | | | | |
| ROX | The law requires that the death centi ate has been signed by the attending bage 2 should be detached for use a | Physician/M | 23b. Was decedent pregr in the past 12 month | 12 | es, outcome of Live birth 2 | Fetal death 3 | Ectopic pregnancy | | | 23d. Date of de Month | livery Day Year |
| л. О. | at the dea by the a stached f | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 | □Pregnant at tin □Unknown | ne of death 5∟ | Other (specify) | | | | , |
| J. | res that ti igned by be detac | y Ph | Part II. Other significant of | conditions contributi | ng to death but r | not resulting in the ur | nderlying cause give | en in Part I. | 23e. Did tobacc | o use contribute to | o the cause of death? |
| rds | quires n sign | ed by | Renal Fai | lure | | | | | 1 🗆 Yes | 2 No 3 P | robably 4X Unknown |
| Records, | aw require ts been si 2 should t | Completed | Hypertens | ion | | | | | 24a. Was an autopsy | 24b. Were a | utopsy findings available completion of cause of |
| | | Com | | | | | | | performed: | death? | V |
| Vital | ician: Th certificate rector, pag | Be | 25. Was case referred to examiner? | medical Hospita | 11* | | Oth | 26. Place of Death | | | |
| | Physical this cral din | -T | 1 ☐ Yes 2 🔀 No 27. Manner of Death | | . Date of Injury | 2 ER/Outpatien | t 3 DOA Othe | 4 23 Nursing Hor | me 5 Residence | | ocify) |
| Division of | ding th. After fune | Certification: | | Pending investigation | (Month, Day Y | (ear) Injury | Work | (? Yes 2 □ No | 200. 00001100 11011 11 | ijarij ososinog | |
| VISI | Attar or dea ector by the | ifica | | Could not be determined 286 | . Place of Injury building, etc. (| - At home, farm, stre | et, factory, office | | 28f. Location (Street City or Town, Sta | | ural Route Number, |
| ā | rs afte rs afte al Dir | Cert | 4 Notified | | ballaling, etc. (| Specify) | | | Only of Town, On | | |
| | Hospi Hou Funar ely fill | Medicai | (Check only 2 N | Certifying Physician ledical Examiner: O | n the basis of ex | camination and/or inv | | | | | |
| | To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director, it | Med | one) 29b. Signature and title of | | nd manner state | ر. دم | 29c. License | number | 29d. [| Date signed (Mont | th, Day, Year) |
| | F ₹ F 8 | | Sho- | X | Das | ami M | D2464 | 18 | 1 | .1/21/05 | |
| | 041 | | 30. Name and address of | person who complet | ed cause of deal | th (Item 23a) (Type, | | - | | _,, 00 | |
| _ | 7 | | Sher A. Has | | VA Mar | yland Hea | lth Care | System I | Perry Poin | it, MD 2 | 21902 |
| | Sta | | 31. Date filed (Month, Day | 2 9 2005 | 326 Registrar's | Signature | and B | | | | |
| | Registr | aı | NOV | ~ 0 =000 | MITTER | 10 P | | | | | |

| | | 1 | For State Registrar | | State o | f Maryla | | partment of ertificate of | Health and find the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of | | giene Reg. No. | 05 | 381 | 90 |
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| | | | Decedent's Name | (First, Middle, Last) | | | | | | 2. Date of Dea Month | ath Day | Year | 3. Tim | e of Death |
| П | Physicia | | Jesse | Gwynn Fe | nder | | | | | Nov | 23 | 2005 | 5: | 45 Am |
| | /Medic Examin | | 4a. Facility Name (If | | | mber) | | 4b. City, Town, | or Location of Deat | h | 4c. Co | unty of Deat | h | |
| | | | Upper Che | sapeake M | medical | L Cente | r | Bel A | | | H | arford | | |
| | Funeral | | 5. Social Security Nu | mber 6. Sex | (| 7. Age (In yrs | s. last birthda | y) If Under 1 Yea Months Day | | | h y, Year) | 9. Birti Co | hplace (Sta untry) | ate or Foreign |
| Ø. | Director | | 238-30-46 | 559 | M 2□F | 82 | Yrs. | | | Oct.30, | 1923 | Nort | h Car | rolina |
| | put 3 | - | Usual Residence of I | Decedent 10b. County | | 10c. C | City, Town or | Location | | | | | 10d. Insid | le City Limits |
| | anyla •ho | 5 | Maryland | Harford | 3 | | Joppa | | | | | | 1 🗆 | Yes 2 No |
| | 28a-1 | ect | 10e. Street and Num | | | | осрра | 10f, Zip Code | | | 10g. Citize | n of What Co | untry? | |
| | h with 23a or | al Dir | | ayton Roa | ad | | | 210 | | | US. | | | |
| 9 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or itema 23a or 28a-f ehow important: If item 27 ie marked other than "natural", or itema 28a or 28a-f ehow any injury or other traumatic event, the Marical Examinatment the multiple at once. | Funeral Director | 11. Marital Status 1 Never Marrie | | Armed F | 2 🗆 No | U.S. 13 | 3. Was Decedent of If Yes, specify Cu | f Hispanic Origin? (Suban, Mexican, Puer lo Specify: | Specify Yes or No to Rican, etc.) | | Race - Ame Black, White pecify: Wh | e, etc. | ń, |
| 21215-0036 | thours sturel, | ed by | | 15. Decedent's Edu | Year or E | Dates: | 16a. De | cedent's Usual Occ | upation | | | of Business/ | | |
| 7. | nun 72 | Completed | (Special Special fy only highest grad | | 1-4or 5+) | life | . DO NOT use reti | | | | | | |
| 2 | d with giene | E | Elementary/3econ | 7 | Conego (| 1 401 517 | Ele | ectrician | | | Elect | rical | Manui | facture |
| פ | al Hyg | Bec | 17. Father's Name (| First, Middle, Last) | | | | | 18. Mother's Na | me (First, Middle, | Maiden Su | ітате) | | |
| <u>a</u> | uld b Menta rrked rific e | 2 | Lundy (| eorge Fe | ender | | | | Maggi | | Ada | | | |
| Maryland | 2 sho and 1 le ma | | | me/Relationship (T) | | _ | | | et and Number or R | | | | _ | |
| Σ | and and n 27 | | | son Fende | - Wi | | | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | Road, Jo | ppa, Mar | | | | |
| Baltimore, | Pages 1 nent of Hu int: If iter iry or oth | | | osition ☐Cremation 3 ☐F 5 ☐Other (Specify) | | | and atoms a | position (Name of rematory or other p Mem. Gar | dens Nov. | | | in City or | | |
| Balti | permit. Departr Imports eny inju | | 21. Signature of Fur | neral Service Licens | 99 | | : | | ress of Facility Messbury Roa | | | | | |
| ph. | | | Immediate Cause (| t failure. List only o Final | ne cause on | each line. | | | lying, such as cardia | | rrest, | | | rimate I Between and Death |
| | /Medical | | disease or condition resulting in death) | • | a. Due to | (or as a cons | equence of). | prator | 7 A | rest | | | 7 | mu = |
| | Examiner | L | Sequentially list on | aditions. | b. Se | as a cons | nauenea ett: | Shock | - | | | | da | ar. |
| | ed isit | liner | if any, leading to im cause. Enter Under Cause (Disease or | rlying injury | 200 | | | | | | | | | |
| | and and II-trar | Examin | that initiated events resulting in death) L | les. | c. Due to | (or as a cons | equence of): | | | | | | | |
| 8760, | cate be executed physician and the burial-transit | alE | | | , C | $V\Delta$. | | | | | | | | |
| 687 | licate phys s the | edical | | | o | | | | | | | | | |
| .O. Box | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown | months? | 1 🗆 Live | utcome of preg birth 2 ∏Fe gnant at time o nown | etal death | 3 □Ectopic pregnal 5 □ Other (specify) | | | 23 | d. Date of de Month | livery Day | Year |
| <u>a</u> | res that the de signed by the a l be detached f | | Part II. Other signif | icant conditions co | ntributing to | death but not r | esulting in th | e underlying cause | given in Part I. | 23e. Did 1 | tobacco use | contribute to | o the cause | e of death? |
| ds, | sign sign d be | d by | DM. | HTW, | CAD | . De | ment | ia P | VD. | 1 🗆 | Yes 2□ | No 3□P | robably | 4 Unknown |
| Vital Records, | The law require | Completed | Genal | failui | , | Dew | biti, | Dear | ndutioned | 24a. Was | | 24b. Were a prior to death? | utopsy find completion | lings available n of cause of |
| a | | | PPM | pracent | ÷ | | | | | 1 Tes | 2 XN0 | 1 🗆 Yes | s 2□ No | - |
| V. | Phyaician: rthis certific ral director. | Be | 25. Was case reference examiner? | | Hospital: | 0 | | 20 BOA | Other | eath Check only | | Other (See | - O. F. () | |
| of | Phys rthis ral di | - To | 1 ☐ Yes 2 ☒☐ 27. Manner of Deat | | 28a. Date | of Injury | ER/Outpa 28b. Tim | e of 28c. In | njury at Work? | 28d. Describe | | | эспу) | |
| on | ding h. Afte fune | ţ | 1-INatural 2 ☐ Accident | 5 Pending investigation | (Mo | nth, Day Year, |) Inju | | Work? □ Yes 2 □ No | | | | | |
| Division | or Attending after death. Director: After in by the fune | Certification: | 3 Suicide 4 Homicide | 6 Could not be determined | 289. Plat | ce of Injury - Alding, etc. (Spe | t home, farm ecify) | street, factory, offi | СВ | 28f. Location (City or To | (Street and wn, State) | Number or R | lural Route | Number, |
| _ | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral | edical C | 29a. Certifier (Check only one) | | iner: On the | | | | e time, date and place ny opinion, death occ | | | | | use(s) |
| | ro the vithin 2 or the omple | Mec | 29b. Signature and | title of certifier | arra ma | | | 29c. Lici | ense number | | 29d. Date | signed (Mon | th, Day, Ye | ar) |
| | / | | 1/ce | contr | -GE | pton | 1777 | UNT MD. | D006 | 2148 | 111 | 23/ | 05- | |
| 1 | 0 | | 30. Name and addr | tess of person who o | completed ca | | tem 23a) (Ty | | lten | · MD | 21 | 237 | | |
| Sept. Chil | St Regist | ate | 31. Date filed (Mon | th, Day, Year) | 2005 | Registrar's Sig | gnature | Coole | | J | | | | |
| | | | | | - // | - | | | | | | | | |

FENDER, JESSE G.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Amend Item 8 per fh G849 11-29-05 Certificate of Death Reg. No 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:10AM 3vd 2005 2 (HOMAS FLOHK NOV /Medical 4b. City, Town, or Locetion of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Baltimore 19459. Birthplace (State or Foreign Country) Lutherville Brightwood Center If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **X**XM 2□ F **Funeral** Months Days Hours Min. 60 Yrs Nov. 16, 2005 Maryland Director 212-44-9777 Usuel Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar estiment of Health and Mental Hygiens, craftering to theme 23e or 28s-f show ortant: if term 272 in marked other than "natural, or items 23e or 28s-f show injury or other traumente event, its Medical Examinational be notified as injury or other traumente event, its Medical Examinationals be notified as XXYes 2 □ No Funeral Director Pulaski VA Pulaski 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1404 Lakeview Drive 24301 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXXNo ₩ Never Married 2 Married 1 Tes X2X No Baltimore, Maryland 21215-0020 Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) College Professor Education 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Ridgely Flohr Mildred Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Rothbaum/Sister 414 Highmeadow Rd. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Buriat 2 Cremation 3 Removal from State Department of Important: if 11/26/05 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Elkridge, MD 21. Signature Funeral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) BRAIN CANCER MONTHS Examiner Due to (or as a consequence of): Physician/Medical Examiner the bunel-transit or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 wo No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV 23rd 2005 MD DOO 53150 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) GURYA 9650 SANTIAGO ROAD ShAKUNMACA

Registrar

State

31. Date filed (Month, Day, Year)

NOV29

2005

ORIGINAL

32. Registrer's Signature

| | | | 1 - For Stete Registrer | State | of Maryla | | | nt of He te of D | | Mental Hy | giene Reg. No. | 000 | 38192 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------|----------------------------------------|-------------------------|----------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------|----------------------------------------------------|
| 4 | Physici | an | Decedent's Name (First, Midd | . , | | | | | | 2. Date of De Month | ath Day | / Year | 3. Time of Death |
| | /Medic | cal | June List 4a. Facility Name (If not institution | elle Froc | | | 4b. City | Town or I | ocation of Deat | NOVEN | 7 | County of Deat | |
| - | Examir | ner | Saint Jos | eph Med | ical (| Center | 45. 0.19, | 10411, 01 2 | | wson | 40. | | altimore |
| | Funeral Director | | 5. Social Security Number 214–84–0122 | 6. Sex | 7. Age (In y | rs. last birthday) 9 Yrs. | If Under Months | | If Under 24 Hrs Hours Min | | th y, 4954 | 9. Bin Off | hplace (State or Foreign untry) |
| | and wo | | Usual Residence of Decedent 10a. State 10b. Count | , | 10c. | City, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| | Mary 9-f eh | tor | Maryland Carr | oll | | West | minst | er | | | | | 1 Yes 2 No |
| | or 28 | Direc | 10e. Street and Number | | • | | 10f. Zip | | | l. | 10g. Citi | zen of What Co | untry? |
| | eath v | eral | 2940 Groves Mi | | edent Ever in | 115 13 | Was Dace | 2115 | | Specify Voc or No | | U.S.A. | rican Indian |
| 036 | within 72 hours after death with the Maryland one. than "neturel", or items 23a or 28e-f ehow the Medical Examinar must be notified at | by Funeral Director | 1 Never Married 2 Mai 3 Widowed 4 Divorce | ried Armed F | orces? 2 ⊉No ive | | | cify Cuban, | | Specify Yes or No to Rican, etc.) | | Black, White | |
| 5 | 72 ho | eted | 15. Deceder (Specify only highe | nt's Education est grade completed |) | (Give | kind of wo | al Occupati | ion ring most of wo | rking | 16b. Kii | nd of Business/ | Industry |
| Maryland 21215-0036 | within piene r than | Completed | Elementary/Secondary (0-12) | | (1-4or 5+) | life. | DO NOT u | se retired) | J | 3 | | Homemak | ter |
| nd | al Hyg d othe | BeC | 17. Father's Name (First, Middle, | Last) | | | | 1 | | me (First, Middle, | Maiden | Sum am e) | |
| yla | narkec | 2 | Lewis H. Fox | | | | | | | e Shard | | | |
| | nd 2 shall hand 27 is n | | 19a. Informant's Name/Relation Dennis M. Frock | | | | | | | Baltimo | | | |
| Baltimore, | permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28e-f ehow eny injury or other traumatic event, the Medical Examinar must be multified at once. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3) | | State | cemetery, crei | matory or o | other place) | | Date 26,2005 | | cation - City or chester | |
| Balt | permit. Departr Importe eny inju | | 21. Signature of Funeral Service | Licensee | | E 6 | Name arckhard 296 Cl | d Address dt Fu harmi | neral C l Dr. M | hapel P. ancheste | A. r, M | ld. 2110 |)2 |
| 1.35 | | | 23a. Part1. Enter the disease, o shock, or heart failure. Lis | r complications that t only one cause on | caused the de each line. | eath. Do not ent | er the mod | te of dying, | such as cardia | c or respiratory ai | rest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | | | IVE HE | ART | FAIL | URE | | | | YEARS |
| - St | Examiner | | | | (or as a cons | VALVE | STEN | OSIS | | | | | |
| | D 15 | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | (or as a cons | sequence of): | | | | | | | |
| | xecute and II-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | (or as a cons | sequence of): | | | | | | | |
| 8760, | licate be executed physicien and s the burial-transit | dicai E | | d | ` | | | | | | | | |
| 9 | ng phy as th | Medi | IF FEMALE: | | | | | | | | | | |
| .O. Box | The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burral-transit | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | birth 2 ☐ Fi nant at time o | etal death 3 | Ectopic pr Other (sp | | | | 2 | 23d. Date of deli Month | very Day Year |
| <u> </u> | quires that t n signed by uld be detai | þ | Part II. Other significant conditi | ons contributing to c | death but not r | resulting in the u | nderlying c | ause given | in Part I. | 23e. Did to | 1 | se contribute to | the cause of death? |
| Vital Records, | The law requir ate has been si bage 2 should | Completed | | | | | | | | 24a. Was autop perfo | sy | 24b. Were au prior to death? | topsy findings available ompletion of cause of |
| /ita | ician: Th certificate rector, pag | Be | 25. Was case referred to medica examiner? | | | | | 7 | | ath (Check only o | - | | |
| | Physic rthis cral dir | . To | 1 Yes 2 No | | | ER/Outpatier | | | 4 Nursing F | lome 5 Resid | | | ufy) |
| ion | Attending Physician: r death. ector: Alter this certific by the funeral director, | ation | Naturat 5 ☐ Pendi 2 ☐ Accident invest | | of Injury oth, Day Year) |) Injury | м | 28c. Injury a Work? 1 □ Ye | s 2□No | 200. 200.000 | io w ii iiui y | Coccurred | |
| Division of | if or Attend after death Director: / | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | nined 286 Plac | e of Injury - Al ling, etc. (Spe | t home, farm, str ecify) | eet, factory | , office | | 28f. Location (S City or Tox | | d Number or Ru | ral Route Number, |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate hi completely filled in by the funeral director, page | Medicai C | 29a. Certifier (Check only one) (Check only one) | ng Physician: To th Examiner: On the b and man | e best of my k pasis of exami nner stated. | knowledge, death ination and/or in- | occurred vestigation | at the time, , in my opin | date and place | and due to the correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, correct at the time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, and time, | cause(s) a | and manner as place, and due | stated. to the cause(s) |
|) | To the within To the comp | Ŵ/ | 29b. Signature and title of certifie |) www | 5. | | 290 | D 37 | number 7254 | | 29d. Date | signed (Month | Dey, Year) |
| 1 | 1 | | 30. Name and address of person | who completed cau | se of death (II | tem 23a) (Type, | Print) | | <u> </u> | | | | |
| V | Sta | te | 31. Date filed (Month, Day, Year, | M. D. 76 | Registrar's Sig | | RIVE | TOWS | HAM MOS | RYLAND | 2120 | 214 | |
| | Registr | | NOV 2 9 2 | 05 | se B | Good | ال | | | | | | |

| Physici | an. | 1. Decedent's Name (First, Middle, Larol Virgin | ia Gerlack | | ment of Hoalth iggten fr Death | 2. Da | te of Death onth | Day Year | 3. Time of Death |
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| /Medic | | Carrol Gerlac | | | | | ember | 22,2005 | 3:44 P |
| Examin | er | 4a. Facility Name (If not institution, g | | | o. City, Town, or Location altimore | of Death | | 4c. County of Dea | th |
| Francis | | 409 S. Payson 5. Social Security Number 6. | Sex 7. Age (In yrs. las | | | r 24 Hrs. 8. Da | te of Birth | 9. Bir | tholece (State or Forei |
| Funeral Director | | 214-64-6427 Usual Residence of Decedent | 1□M 255 49 | Yrs. M | onths Days Hours | Min. 10/ | te of Birth onth, Day, Ye 09/195 | 66 M | thplece (State or Foreignuntry) D |
| MON | | 10a. State 10b. County | 10c. City, | Town or Locati | on | | | | 10d. Inside City Limit |
| a-f s-f | tor | MD N/A | Balti | imore | | | | | 1 Exres 2 □ N |
| "natural", or Itams 23a or 28a-f show edical Examiner must be notified at | Funeral Director | 10e. Street and Number | | 1 | 10f. Zip Code | | | Citizen of What C | - |
| 230 | ra | 409 S. Payson St | treet | | 21223 | | | ited Sta | |
| Itams Carre | nue | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was | Decedent of Hispanic O ss, specify Cuban, Mexica | rigin? (Specify Yean, Puerto Rican, | etc.) | 14. Race - Am Btack, Whi | |
| N. B. | | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 No If Yes, Give Year or Dates: | 1 🗆 | Yes 250 Specify | / : | | Specify: | White |
| a di E | Completed by | 15. Decedent's | | 16a. Decedent | 's Usual Occupation | | 16b | . Kind of Business | /Industry |
| u di | piet | (Specify only highest g | | (Give kind | d of work done during mo NOT use retired) | st of working | | | , |
| and Mental Hygiene. Is marked other than Burnatic event, Ins M. | E | 10 | College (1-401 3+) | homem | aker | | | own hom | e |
| t of result and Mental rigglene. If item 27 is marked other than or other traumatic event, the M | Bec | 17. Father's Name (First, Middle, La. | st) | | | ner's Name (First, | Middle, Maid | den Sumame) | |
| ind Mental markad o umatic eve | ToE | Albert Donald Wi | ithrow | | My | rtle Shr | aver | | |
| | | 19a. Informant's Name/Relationship | (Type, Print) | 19b. Maiting A | ddress (Street and Numi | ber or Rural Route | e Number, Cit | ty or Town, State, | Zip Code) |
| of Health litern 27 r other tra | | Deborah Withrow, | | | reeway Hale | | | .227 | |
| if ite | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 | сеп | ce of Dispositionetery, cremato | orv or other place) | Dec. 01,2 | MAC | . Location - City or | |
| artment ortent: t injury o | | * 4 □ Donation 5 □ Other (Spec | city) Criesa | - | or chargery | | De | ltsville | , |
| Department of Importent: If any injury or once. | | 21. Signature of Funeral Service Lic | ensee. | 22. Na | ame and Address of Faci | | -A 1 | -d Fure | 12128 |
| | | dynda Sue t | WW 1101443 | | | | | res Dr. B | |
| | | | implications that caused the death. by one cause on each line. | Do not enter tr | ne mode of dying, such a | s cardiac or respi | ratory arrest, | | Approximate Intervat Between Onset and Death |
| sician | | tmmediate Cause (Final disease or condition resulting in death) | a. Atherosclerot | ic Card | liovascular | Disease | | | |
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| ith the Maryland or 28a-f show | | 10a. State 10b. County | 10c. C | BAHIN | | | | _ | | 10d. Inside City Limits 1 Yes 2 No |
| with the a or 28a | Direc | 10e. Street and Number | 4L | | 10f. Z | ip Code | | 11 | Og. Citizen of W | , |
| ite; Marylating ZIZIO-000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic avent, the Medical Expriner crust be notified at | by runeral Director | 4/3 E. Bidd (E 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give | | Was Deci | odent of Hispani ecity Cuban, Me | | acify Yes or No- Rican, etc.) | 14. Race | - American Indian, k, White, etc. |
| thin 72 hour e. | Completed b | 15. Decedent's Ed (Specify only highest gra | Year or Dates: ucation de completed) College (1-4or 5+) | (Give | kind of w DO NOT | ual Occupation ork done during use retired) | most of work | ing | 16b. Kind of Bus | ŕ |
| in yielile A I A should be filed within the Menial Hygiene. marked other than matic avent, the Menial A A A A A A A A A A A A A A A A A A A | e n | 17. Father's Name (First, Middle, Last) MELUW GROWN | le | Car | 15tru | 18. N | 1. 11 | a (First, Middle, N | CUN6/V Maiden Surname | |
| e, Maryla 1 and 2 should Health and Men em 27 is marke other traumatic. | | 19a Informant's Name/Relationship (1) | hard son | 413 | E. 18 | BIddle 3 | lumber or Rura | al Route Number, | - | State, Zip Code) 205 City or Town, State |
| Page Page nent o ant: If ury or | | 20a. Method of Øisposition 1 ☐ B urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | Place of Dispo cemetery, crer 1+ CAMME | | | | los Funer | | |
| Descrit. Depertrimporta | | 21. Signature of Funeral Service Licen | \$60 L | 22 | 2. Name a | | | 45 Funer | | 21713 |
| Physician | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition | one cause on each line. | ath. Do not ent | | | | | , | Approximate Interval Between Onset and Death |
| /Medical Examiner | | resulting in death) Sequentially list conditions, | b. Supe to (or as a const | | | | | | | |
| ate be executed hysicien and the buriat-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a conso | d Imi | nu | re De | ticien | ey Sy | ndron | ne |
| ate be hysicie he bur | edical | | d | | | | | | | |
| death cert death cert e attendin d for use | Physicianim | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown | tal death 3 | Ectopic | pregnancy specify) | | | 23d. Date Mon | e of delivery th Day Year |
| ecords, F.O. law requires that the es been signed by th 2 should be detache | 2 | Part II. Other significant conditions o | ontributing to death but not r | esulting in the u | nderlying | cause given in I | Part I. | | | bute to the cause of death? |
| The law receipt he specified has be | Completed | | | | | | | 24a. Was an autops perform | y ned? pr | Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No |
| OI VICAL Physicien: 1 rthis certifical ral director, p | o ne | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 Inpatient 2 | ☐ ER/Outpatier | nt 3 🗆 🗅 | Other | | me 5 ☐ Reside | | or (Specify) |
| Attending Phy ar death. ector: After this by the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the f | ation: I | 27. Manner of Death 1 D Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | f M | 28c. Injury at Work? 1 ☐ Yes | | 28d. Describe ho | | |
| | Certification: | 3 Suicide 6 Could not be determined | building, etc. (Spe | cify) | | | | City or Town | , State) | or or Rural Route Number, |
| n 24 ho n 24 ho he Fune | edical | 29a. Certifier 1 Cartifying Ph (Check only one) 2 Madical Exam | ysician: To the best of my k niner: On the basis of exami and manner stated. | nowledge, deat nation and/or in | h occurre vestigatio | d at the time, da n, in my opinion | ate and place, n, death occurr | and due to the ca red at the time, da | ause(s) and man ate and place, a | nner as stated. nd due to the cause(s) |
| To t withi To t | Σ | 29b. Signature and title of certifier | n D | | 1 | 9c. License num 895 | | | | (Month, Day, Year) |
| 17 | | 30. Name and address of person who hang our atte | completed cause of death (It | em 23a) (Type, | Print) | n.D. | 40 m | rylan | & Gene | 105 eral Hospital |
| Stat Registra | | 31. Date filed (Month, Day, Year) | 32. Registrar's Sig | nature A | Costo | 1 | | | | |

| | | • | . FOI | partment of Health and M <i>ertificate of Death</i> | lental Hygier | 000 00100 |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | 2. Date of Death | 3. Time of Death |
| | Physicia | | Avis A. | Green | | 24 2005 7:45 AM |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death |
| | LAUMMI | Ŭ., | Sinai Hospital of Bultimore | - Baltimore City | 1 | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo | ay) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea | 9. Birthplace (State or Foreign |
| | Director | | 214-96-6405 1 M X 7 74 Yrs | Months Days Hours Min. | 11 05 | 31 Jamaica |
| - | 0 | | Usual Residence of Decedent | | | |
| - | how | | 10a. State 10b. County 10c. City, Town or | Location | | 10d. Inside City Limits |
| | s -t-s | to | MD NA Balti | more | | 1X Yes 2 □ No |
| - | or 28 | Director | 10e. Street and Number | 10f. Zip Code | 10g. 0 | Citizen of What Country? |
| | 23a | | 5311 Nelson Ave | 21215 | | Jamaica |
| | B E | Funerai | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto | acify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 2 | or it | Fu | XXNever Married 2 ☐ Married 1 ☐ Yes 2XN No | 1 ☐ Yes 2 ☐ No Specify: | , | 0 |
| 3 | in in in in in in in in in in in in in i | d by | 3 Widowed 4 Divorced Year or Dates: | | | Black |
| 5 | natu | Completed | 15. Decedent's Education 16a. De (Specify only highest grade completed) (G | cedent's Usual Occupation ive kind of work done during most of worki e. DO NOT use retired) | ing 16b. | Kind of Business/Industry |
| 1 | Almin Den. | mpi | Elementary/Secondary (0-12) College (1-4or 5+) | | | |
| 4 | lygien her ti | | | eietary Aid | | ursing Home |
| | Z should be liled within 7.2 hours after death with the maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show aumetic event, the Madical Examinational Leadified at | Be | 17. Father's Name (First, Middle, Last) | | (First, Middle, Maid | en Sumame) |
| × . | Men Arke arke | ဥ | Leslie Green | Virgini | | |
| | and is m | a f | | ailing Address (Street and Number or Rura | | |
| <u>.</u> | is 1 and 2 should be lied within 72 hours after death with the marylar of Health and Mental Hygiene. I then It is marked other than "natural", or itams 23a or 28a-f show titem 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, If a Medical Examiner must be multified at | | 00000 | 1 Nelson Ave, Ba | | |
| | of Hi | | 20a. Method of Disposition 20b. Place of Di cemetery, (cemetery, (| crematory or other place) | | Location - City or Town, State |
| | rages ment of t ant: If its ury or o | | `4 □Donation 5 □Other (Specify) Druic | Ridge 12/0 | 03/05 Pil | kesville, Md |
| משו | permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility March F/H West 4300 Wabash Ave | Baltimo | ore, Md 21215 |
| | 40.00 | | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock or heart fail ite. List only one cause on each line. | | | Approximate |
| | 2.134 | | shock or heart fall re. List only one cause on each line. Immediate Cause (Final | 1 of Parking | | Interval Between Onset and Death |
| F | hysician /Medical | | | heart failure | <u></u> | Syears |
| | Examiner | | Due to (or as a consequence of): | | | |
| | | P. | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | |
| J | nsit | ri I | Cause (Disease or injury | | | |
| | al-tra | Examiner | that initiated events c. resulting in death) Last C. Due to (or as a consequence of): | | | |
| 0000 | icate be executed physician and sthe burial-transit | dicai | d | | | |
| 0 | ificati g phy as the | | | | | |
| Š | The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as | Physician/M | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death | 2 Totasia seessasse | | 23d. Date of delivery |
| 0 | death e atte d for | icia | in the past 12 months? 4 Pregnant at time of death | 3 Ectopic pregnancy 5 Other (specify) | | Month Day Year |
|) | oy the | hys | 9 ☐ Unknown | | | |
| , | s tha ned l | by P | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobacc | o use contribute to the cause of death? |
| cords, | quire n sig uld b | | atrial fibrillation | | 1 🗆 Yes | 2 ☑No 3 ☐ Probably 4 ☐Unknown |
| 2 | s bee | Completed | Severe pulmonary hy | pertension | 24a. Was an | 24b. Were autopsy findings available |
| ב | he la e has age 2 | шc | | pa (crister) | autopsy performed | |
| | | Ö | 25. Was case referred to medical | 26 Place of Death | 1 Yes 2 1 | No IL 165 ZEINO |
| > | Physician: r this certific ral director, | 0 0 | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa | Othor | | 6 ☐Other (Specify) |
| 5 | Phy er this eral d | - | 27. Manner of Death 28a. Date of Injury 28b. Tim | e of 28c. Injury at | 28d. Describe how in | |
| 5 | th: After | tlo | 1 ⊠Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation | ry Work? M 1 ☐ Yes 2 ☐ No | | |
| DIVISION | Attan deal ctor y the | fica | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm | , street, factory, office | | and Number or Rural Route Number, |
| 2 | after Dire | Certification: | 4 Homicide Seterifined building, etc. (Specify) | | City or Town, Sta | ate) |
| | To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, d | | | |
| | 24 h 24 h e Fui | edical | (Check only 2 Medical Examiner: On the basis of examination and/cone) and manner stated. | | | |
| | Vithin Fo th | Me | 29b. Signature and title of certifier | 29c. License number | | Date signed (Month, Day, Year) |
| | . > - 0 | | TO DE MP | RES-000 | NI | vember 24, 2005 |
| | 2 | | 30. Name and address of person who completed cause of death (Item 23a) (Ty | 610 | | |
| | 7 | | Exika Olander, MD Sin | ai Hospital of | Raltim | ore |
| | Sta | ate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | ai Hospital of | <u> </u> | _ |
| | Registi | | NOV Z 9 2005 Block & Com | المالية | | |
| | | | 2 | | | |

| Please Type or | Print in | Black | Indelible Ink. | Ensure All | Copies | Are Legible |
|----------------|----------|-------|----------------|------------|--------|-------------|
| | | | | | | |

| DONALD HERBERT GRAY Medical Examiner Medical E | 8760, cate be executed | | 49 | | | | | 1 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| A. Facility Name (if not institution, give street and number) A. Facility Name (if not institution, give street and number) A. Facility Name (if not institution, give street and number) A. Facility Name (if not institution, give street and number) A. Facility Name (if not institution) A. Facility Name (if not ins | /M Exa | ledical aminer | | disease or condition resulting in death) a. Due to CARD Sequentially list conditions. | (or as a consequence of): IOMYOPATHY | FAILURE | | On | set and Death |
| DONALD HERBERT GRAY Medical Examiner Medical Examiner Marbury Road Montgomery | | | | 20a. Method of Disposition 1 | State 20b. Place of Dispo- cometery, crem Montgom Cremato 22 Be M00335 Be aused the death. Do not enter | isition (Name of natory or other place) lery Norium, Inc. 25 Name and Address of Facility Rothesda—Chevy Chatchesda, Maryland | ovember 5, 2005 bbert A. Pu 1se, Inc. 7 | Bethesda Manual Residential Re | State Tryland ral Home/ in Avenue proximate eval Between |
| DONALD HERBERT GRAY Medical Examiner Medical Examiner Marbury Road Montgomery | ryland 2121 hould be filed within d Mental Hygiene. | marked other than "matic event, II w M. | ם ם | 7. Father's Name (First, Middle, Last) George A. Gi | ray. Jr. | Sales 18. Mother's Na | me (First, Middle, Mai | iden Sumame) era Sweet | |
| DONALD HERBERT GRAY Medical Examiner Medical Examiner Marbury Road Montgomery | 5-0036 72 hours after death with the | iteal Examiner must be noted | Dy ruingian | 0e. Street and Number 7700 Marbury Ro 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education | 16a Deced | 10f. Zip Code 20817 Vas Decedent of Hispanic Origin? (: Yes, specify Cuban, Mexican, Pue □ Yes 2 No Specify: | Specify Yes or No- to Rican, etc.) | United Si 14. Race - American I Black, White, etc. Specify: | tates ndian, |
| Medical Examiner DONALD HERBERT GRAY NOVEMBER 20, 2005 11:30 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death | Di | irector | 1 | Social Security Number 215-46-2459 Isual Residence of Decedent Oa. State 10b. County | 7. Age (In yrs. last birthday) 60 Yrs. | Months Days Hours Min | . (Month, Day, Ye | 9. Birthplace Country) 1945 Cali | (State or Foreign |
| Month Day Year | | /Medical | 1 - | a. Facility Name (If not institution, give street and num | nber) | | NOVEMBER : | 20, 2005 4c. County of Death | 11:30 P ^M |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 0 2005 0046 HNTHONY DONALD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harbor Hospital Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10 M 2□ F 2/5-86-5083 Usual Residence of Decedent Yrs. 09-06-Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. r than "natural", or Items 23a or 28a-f ehov the Modical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A 1615 STREET 21226 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 CEREAL DALTO. MO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OSCHELL MEM. GARDENS 11-02-05 22. Name and Address of Facility HILLIP A. WEATHERFORD FUNETIL Ser 21. Signature of Funeral Service Licensee STREET 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the a completely filled in by the tuneral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of d ath?

1 10 es 2 □ No 24a. Was an autopsy performed? Yes 2 No 10 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ∑Yes 2 □ No 2X ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 23/05 1 ☐ Yes 2 No 2348 Horizs 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 4 Homicide Cleric

Division of Vital

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

THEODORE M. 1419 31. Date filed (Month, Day, Year)

30. Name and address of person who completed caused

32. Registrar's Signature

ww)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

death (Item 23a) (Type, Print) 111 Penn Street

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number OCME

29d. Date signed (Month, Day, Year)

October, 24, 2005

Baltimore, Maryland 21201

| | | | FOI | partment of Health and Me Pertificate of Death | ntal Hygier | 2005 3 | 8199 |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------|------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | . Date of Death | 3 | 3. Time of Death |
| | Physicia /Medic | | Michael Patrick Harringto | n N ₁ | | 25 2005 | 5:50 A M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | c. County of Death | 0100 // |
| | | | 6723 Thruway | Dundalk | | Baltimore | |
| П | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda | Months Days Hours Min. | . Date of Birth (Month, Day, Yea | r) Country) | |
| | Director | | 212-60-8324 53 Yrs. Usual Residence of Decedent | | July 28 | 1952 | MD |
| | nylanc how | | 10a. State 10b. County 10c. City, Town or | Location | | | Inside City Limits |
| | Ba-f s | cto | Maryland Baltimore | Dundalk | | | 1 ☐ Yes 2 ☒ No |
| | vith th | Dire | 10e. Street and Number | 10f. Zip Code | 10g. (| Citizen of What Country' USA | ? |
| | eath v | erai | 6723 Thruway 11. Marital Status 12. Was Decedent Ever in U.S. 13 | 21222 3. Was Decedent of Hispanic Origin? (Specific | fv Yes or No- | 14. Race - American | Indian. |
| Baltimore, Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 le marked other then "naturel", or Items 23e or 28e-f show or other treumetic event, the Madical Examiner mat be multiled. | by Funeral Director | Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Meyer Married 2 Married 1 Meyer Married 1 Meyer Married 1 Meyer Meyer or Dates: | Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric □ Yes 2 \ No Specify: | can, etc.) | Black, White, etc. Specify: Whit | |
| 2-0 | 72 ho | Completed | 15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi | cedent's Usual Occupation ve kind of work done during most of working | 16b. | Kind of Business/Indus | try |
| 21 | vithin ne. hen * | Jdm | Elementary/Secondary (0-12) College (1-4or 5+) | . DO NOT use retired) Fabricator | İ | eel Manufac | cturing |
| 15 D | filed v Hygle ther t | e Co | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (F | | | cui mg |
| au | id be ental ked o | To Be | Chester Harrington | Mary | Cellers | | |
| ary | shou and M e mar | - | 19a. Informant's Name/Relationship (Type, Print) 19b. Ma | iling Address (Street and Number or Rural R | Route Number, City | y or Town, State, Zip Co | ode) |
| Σ | and 2 salth a n 27 l | | | 23 Thruway, Dundalk, | MD 2122 | 2 | |
| ore | ges 1 t of He If iter or oth | | 1 V Burial 2 Cromation 2 Personal from State Cemetery, C | position (Name of Permatory or other place) | 29 | Location - City or Town | |
| ţ | t. Pag rtment rtent: njury | | 4 Donation 5 Other (Specify) Mary land | veterans tem 2005 | 5 urd | wnsville, M | |
| Bal | permit. Pages 1 and Department of Heall Importent: If item 2 any Injury or other 90cg. | | 21. Signature of Yuneral Service Longary | 3111 Mountain Road. | Pasadena | Funeral Hor , MD 21122 | ne, P.A. |
| П | | | 23a. Part 1. Enter the disease, or complications that paused the death. Do not a shock, or heart failure. List only one cause on each line. | nter the mode of dying, such as cardiac or re | espiratory arrest, | 1nt | pproximate terval Between nset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | smutosis | | | ISS BIIG DOLLI |
| | /Medical Examiner | | Due to (or as a consequence of): | in the Liver | | | |
| | | ē | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | e of housen | | - | |
| | cuted od ransit | Examiner | if any, leading to immediate auto Enter 13 Jan 2 Cause (Disease or injury that initiated events | | | | |
| Ö, | cate be executed physician and the burial-transit | | resulting in death) Last Due to (or as a consequence of): | | | | |
| 8760, | cate b physic the b | dical | d | | | | |
| 9 xc | eath certific attending p | /Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | 23d. Date of delivery | |
| . Box | p op | Physician/Me | in the past 12 months? 1 Vec. 3 No. 4 Pregnant at time of death | I □Ectopic pregnancy I □ Other (specify) | | Month Da | y Year |
| P.0 | requires that the d een signed by the nould be detached | hys | 9 ☐ Unknown | | | | |
| | ign ed | | Part II. Other significant conditions contributing to death but not resulting in the | | | o use contribute to the c | ause of death? y 4 [Unknown |
| orc | v requir | eted | Depatocellulan Cance | | | | |
| Vital Records, | as 2 | Completed by | To Hera o dero watos | <u>- S</u> | 24a. Was an autopsy performed? | 24b. Were autopsy prior to comple death? | findings available etion of cause of |
| = | | e Co | 25. Was case referred to medical | 20 Blood Book (| 1 Yes 2 7 | |] No |
| | Physicien: this certific ral director, | 0 | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat | 26. Place of Death (Content 3 DOA Other: 4 Nursing Home | | 6 ☐Other (Specify) | |
|) of | ng Phye ter this neral di | n: T | 27. Manner of Death 28a. Date of Injury 28b. Time | of 28c. Injury at 28c | d. Describe how in | | |
| ior | Attending r death. sctor: Afler | atio | 2 Accident investigation | M 1 ☐ Yes 2 ☐ No | | | |
| Division | after de Direct | ertification; | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | street, factory, office 28f. | f. Location (Street City or Town, Sta | and Number or Rural Ro ate) | oute Number, |
| | To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral | edical C | 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or and manner stated | ath occurred at the time, date and place, and investigation, in my opinion, death occurred | d due to the cause at the time, date a | (s) and manner as state and place, and due to the | d. e cause(s) |
| (2) | To the within 2 To the complet | Med | and manner stated. 29b. Signature and title of certifier | 29c. License number | 29d. E | Date signed (Month, Day | v, Year) |
| | 14 | | Bak In the Mary | D 20807 | N. | 20 / 200 | 3% |
| | 7, | | 30. Name and address of person completed a use of death (Item 23a) (Typ. Dr. Yorkoff, 10 Greene Street, Bal- | | | With Fire Control | • |
| | Sta Registi | | 31. Date filed (Month, Day, Year) NOV 2 9 2005 | | | | |
| | | | MAN 2 COOL COMPANY | 7 | | | |

State of Maryland / Department of Health and Mental Hygiepe 05 38200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death NOVEMBER 21,2005 **Physician** 9:42 P^{M} M.D. Donald William Osler Hughes, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 213-28-2124 Usuel Residence of Decedent 24,1932 Maryland Director 73 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I show ir than "natural", or items 23a or 28a-f ehov The Medical Examiner must be nuttilled at 1 Yes 2 No Funeral Director Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 East Lake Avenue 21212 Usa 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ▼Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ 3 Widowed 4 Divorced Colored Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Practice permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien important: if item 27 is marked other ft any injury or other traumatic event, Lt. once. Medical Doctor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Singleton Bernard Hughes, M.D. Blanche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandra Hughes(Daughter) 1102 E. 36th St., Baltimore,MD. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenmountCrematory11-25-05 Baltimore, MD. 21. Signator of Fur eral Service 22 Name and Address of Facility Joseph H. Brown Jr. Funeral 2140 N. Fulton Ave., Balto. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SHOCK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any loading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospitel or Attending Physician: The law requires that the death certificate be executed ADENOCALCINIMA OF SULL FOUEL Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funerel Director: After this certific, completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Mannor of Death 1 Natural 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerei I 12 Cartifying Physician: To the best of my knowledge disath occurred at the time. Jate and disea and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified G569 N. CharlesSt Ste 601 TOWSON, 41D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2005 Registrar

| | | 1 | For State Registrar | State of Maryla | and / Depa | artment of H rtificate of L | ealth a | and M | F | Reg. No. | 005 | 38201 |
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| | Physicia | | 1. Decedent's Name (First, Middle, La | | | | | | 2. Date of Dea Month | ath Day 19 | Year 2005 | 3. Time of Death |
| | /Medic | al | Evelyn Lockhart 4a. Facility Name (If not institution, gin | | | 4b. City, Town, or | Location of | of Death | 11 | | ounty of Dea | 06:45 m |
| | Examin | er | Rockville Nursi | | | Rockvi | | | | Me | ontgom | ery |
| | Funeral Director | | | Sex 7. Age (In your 10 M 20€) 7. Age (In your 11 M 20€) 7. Age (In your 12 M 20€) | rs. last birthday) Yrs. | If Under 1 Year Months Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Day 12-12- | 1915 | 9. Bir C M | thplace (State or Foreign ountry) aine |
| , | w w | | Usual Residence of Decedent 10a. State 10b. County | 10c. | City, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| | Maryli f sho | tor | MD Montgo | mery | Bethesd | a | | | | | | 1 ☐ Yes 2,☐(No |
| | sa or 28a | Il Direc | 10e. Street and Number 10600 Kenilwort | h Ave Apt 1 | | 10f. Zip Code 2081 | 4 | | | - | en of What C | ountry? |
| 336 | perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Items 23a or 28a-f show any injury or other traumatic event, the Modreal Examination and item and once. | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☆ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No | | gin? (Spe n, Puerto | ecify Yes or No- Rican, etc.) | 1 | I. Race - Am Black, Whi pecify: W | |
| Maryland 21215-0036 | thin 72 hou e. en "netura Wedical E | Completed | 15. Decedent's E (Specify only highest gi | College (1-4or 5+) | (Give | dent's Usual Occupa kind of work done of DO NOT use retired | ation during mos d) | t of worki | ing | | d of Business | |
| 2 | led wil lygien her tha | Con | 17. Father's Name (First, Middle, Las | 4+ | Lib | rarian | 18 Mothe | er's Name | (First, Middle, | | | chools |
| yland | buld be fi Mental H arked ott atic ever | To Be | Harley Lockhart | <u>u</u> | | | G1 | adys | Ditson | Loc | khart | To Code) |
| Mar | alth and 27 is m | | 19a. Informant's Name/Relationship Paul Hurlburt/s | | | ng Address <i>(Street a</i> | | | | Sethe | sda MD | 20814 |
| Baltimore, | Pages 1 and of Hering III it is the III it is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or other III is an or | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control | Removal from State | b. Place of Dispo cemetery, cre Chesape | osition (Name of matory or other place ake Crema | tory | 11-2 | 5-2005 | | ation - City o | r Town, State e MD |
| Balti | perrit. Dep rtn Imports any inju | | 21. Signature of Puneral Service Lice | Commany | - | 2. Name and Addres Rapp Fun 933 Gist | eral Av S | & Cr Silve | r Sprin | e MD | | |
| | Pnysician /Medical Examiner | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Punemonia | | | | | | | | | Approximate Interval Between Onset and Death |
| | | | resulting in death) | Due to (or as a con Dementia | sequence of): | | | | | | | |
| | n ä | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a con | MO 65790 D84 | | | | | | | |
| × | be executed ician and burial-transit | Kam | Cause (Disease or Injury that initiated events resulting in death) Last | c. Chronic Rep | | Lure | | | | | | |
| 8760, | 5 × 6 | dical Examiner | • | d. Diabetes Mo | | | | | | | | |
| .O. Box 68 | death certif e attending id for use a | Physiclan/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown | etal death 3 | □Ectopic pregnancy | / | | | 23 | 3d. Date of de Month | elivery Day Year |
| S, D | Se G | by | Part II. Other significant conditions | contributing to death but not | resulting in the | underlying cause giv | en in Part I | l. | | obacco us Yes 2□ | | to the cause of death? Probably 4 Dunknown |
| Record | e law has b | Completed | | | | | | | 24a. Was autopento 1 Yes | | 24b. Were a prior to death? | |
| Vital | sicien; Th certificate rector, pag | Be (| 25. Was case referred to medical examiner? | Hospital: | | Oth | | | h (Check only o | | | |
| of | Phys r this ral dii | To To | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury (Month, Day Yea | 2 ER/Outpatie | ant 3 DOA | 4 (24) | ursing Ho | ome 5 Resi 28d. Describe | | | ecify) |
| ion | Attending In death. ector: After by the funer | atlon | 1 □Natural 5 □ Pending 2 □ Accident investigat | | r) Injury | | rk? Yes 2. ☐ | No | | | | |
| Division | - i to | Certification: | 3 □ Suicide 6 □ Could not 4 □ Homicide determine | | | treet, factory, office | | | 28f. Location (City or To | | Number or I | Rural Route Number, |
| | Hospite 4 hours Funerel | Medical C | 29a. Certifier Check only one) Check only 2 Medical Ex | Physician: To the best of my aminer: On the basis of exar and manner stated. | knowledge, dea πination and/or i | th occurred at the til nvestigation, in my o | me, date a | nd place, ath occur | and due to the red at the time, | cause(s) a date and | and manner a place, and du | as stated. se to the cause(s) |
| | To the Hos within 24 h To the Fur completely | Me | 29b. Signature and title of certifier | .1 0 | | 29c. Licens | e number | | | 29d. Date | signed (Mor | nth, Day, Year) |
| | _ | | Noin | | sunn | | 330 | | | 1 | 1-23-2 | 005 |
| | 10 |) | 30. Name and address of person wh | eph 50 West E | | | f1. R | ockv | ille MD | 2085 | 52 | |
| | St Regist | ate trar | Dr. Thomas Jos 31. Date filed (Month, Day, Year) NOV 2 9 20 | 2. Registrar's S | ionature | | <u> 1</u> | JUNV | TITE III | 200 | - | |

State of Maryland / Department of Health and Mental Hygiene 38202 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:45 PM Mary Lynn Trinkle Hendel November 2005 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, NOV 30, 19 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2QF 213-84-7873 43 Yrs. V<u>irginia</u> Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examinational be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Crownsville Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 711 Whitneys Landing Road 21032 USA Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: "natural", # Health and Mental Hygiene.
Item 27 is marked other then "natur
other traumatic svent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Catering Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elbert Norred Trinkle Jr. Patricia Thomas Benoit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Thomas Benoit, Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of I
Importent: If It
any injury or o
once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/29/05 Baltimore, Maryland 21. Signature of Funeral Service ^{22. Name and Address of Facility} Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Fromas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATIC ENCEPHALOPATHY LYAG **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** LIVER THE (FAR) CIRRITOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed ALCOHOLIUM Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 □ Yes 2 □ No peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 Tyes 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 🖨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051437 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OKEDWO DARCY AAMC ANNAPOLIS MD 21401 IBITOYE 31. Date filed (Month, Day, Year) adjistrar's Signature State NOV 2 9 2005 Registrar

DHMH 17 Rev 1/2001

| | | | 1 _ For State | State of Ma | aryland / | | tment of F | | nd Mental Hy | 20 | 05 | 38203 |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------|------------------------------------------------------------|------------------------|-----------------------------|--------------------------------|---------------------------|---------------------------------------------|---------------------------------|-------------------------------------|---------------------------------------------|
| 1 | 7 | | Registrar 1. Decedent's Name (First, Midd | dle, Last) | | Oerti | ilicate of | Dealii | 2. Date of D | | | 3. Time of Death |
| 3 | Physici /Medic | | MARTHA L. | HILL | | | | | Nove | mber 2 | 7 20RS | 10:35 PM |
| | Examin | er | 4a. Facility Name (If not institution | ion, give street and number) | 1901 | al | 4b. City, Town, o | . 11 . | 0 0 | 4c. Cour | nty of Death | |
| | Funeral | 315 | 5. Social Security Number | 96. Sex 7. Ag | e (In yrs. last | | If Under 1 Year Months Days | If Under 24 | | irth ay, Year) | 9. Birtho | place (State or Foreign |
| 84 | Director | | 220 · 38 · 9982 Usual Residence of Decedent | 1 □ M 2 Q F | 67 | Yrs. | Mortins Days | nouis | 09.20. | 1938 | Cour | NC NC |
| | yland | | 10a. State 10b. Count | ty | 10c. City, T | own or Loca | ation | | | | 1 | 0d. Inside City Limits |
| | 8e-f el | Director | | A | BALTIT | MORE | | | ····· | | | 1 🖺 Yes 2 🗌 No |
| | with th | | 10e. Street and Number 4602 COLEHER | INE ROAD | | | 10f. Zip Code | | | 10g. Citizen o | of What Cour | ntry? |
| | be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or items 23a or 28e-f ehow event, the Mudical Examiner must be mailled at | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | Ever in U.S. | 13. Wa | as Decedent of H | lispanic Origin | n? (Specify Yes or N Puerto Rican, etc.) | | Race - Americ | |
| 36 | s after | by Fu | 1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce | arried 1 ☐ Yes 2 🔀 | | | Tes, specify Cuba | Specify: | ruerto nican, etc.) | | Black, White, c <i>ify:</i> BLAC | |
| 215-0036 | 2 hour | | 15. Decede | ent's Education | 1 | 6a. Decede | nt's Usual Occup | ation | | | Business/In | |
| 215 | ithin 7. ne. nen "n | Completed | Elementary/Secondary (0-12) | nest grade completed)) College (1-4or ! | 5+) | life. DO | nd of work done | during most o d) | f working | 2.20 | | · |
| d 21 | filed Hygi ther | e Cor | 12 TH GRADE 17. Father's Name (First, Middle | e, Last) | | HOME | MAKER | 18. Mother's | s Name (First, Middl | | NESTIC | |
| lan | should be nd Mental marked o | To Be | | SHARPE | | | | | A WILLO | | | |
| Maryland | and and em | | 19a. Informant's Name/Relation | | | | | | or Rural Route Num. | | | Code) |
| | s 1 and 3 f Heelth item 27 l | | MAURICE HILL 20a. Method of Disposition | . (HUSBAND) | 20b. Place | e of Disposit | COLEHE | 1 | Date Date | IMORE 20c. Locatio | MD in - City or To | 21224 own, State |
| Baltimore, | 0 0 | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (| n 3 Removal from State (Specify) | | - | itory`or other plac FOREST | 1 | .01.05 | OMINIGS | MIII | S MD |
| 3alti | permit. Pag Department Importent: I eny injury o | | 21. Signalure of Fureral Service | e Licensee | / | | | | UNERAL SEI | EVICE | C | S, 17112 |
| 20 | 20 E ● a | | 23a. Part1. Enterthe disease, | or complications that cause | the death [| 515 | BALTO. N | ATT PIKE | E. BALTO. A | 10 2122 | 9 | Approximate |
| 1 | Physician | | Immediate Cause (Final | ist only one cause on each li | ne. | 1 - | c. | 0 | Ce Y | arrest, | | Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | a. Due to (or as | a consequen | | | MI | | | | 6 1411/10 |
| | Examiner | 7 | Sequentially list conditions, if any, leading to immediate | b. — Due to (or as | a consequen | nce of): | | | | | | |
| $\sqrt{}$ | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | 1 | | .00 017. | | | | | | |
| ,00 | cate be executed physician and the burial-transit | Exe | resulting in death) Last | Due to (or as | a consequen | nce of): | | | | | | |
| 38760, | phy: | dlcal | | d | | | | | | | | |
| Box (| death certiff e ettending id for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | ctopic pregnancy | , | | 23d. I | Date of delive | ery |
| O. B | ne deati the ette hed for | sicie | in the past 12 months? 1 ☐ Yes 2 ☑ 10 9 ☐ Unknown | 4☐Pregnant a 9☐Unknown | | | Other (specify) | | | | Month | Day Year |
| Δ, | The law requires thet the de ate hes been signed by the e page 2 should be detached t | | Part II. Other significant condi | itions contributing to death t | out not resultin | ng in the und | lerlying cause giv | en in Part I. | 23e. Did | tobacco use co | ontribute to the | ne cause of death? |
| Records, | w requires been sign should be | ed by | [| | | | | | 1 | Yes 2 10 | 3 □ Prob | pably 4 Unknown |
| lecc | e law re hes be | Completed | | | | | | | 24a. Wa | ODSV | prior to co | psy findings available mpletion of cause of |
| alF | ician: The l certificate he rector, page | | 25. Was case referred to medic | 201 | | | - | | 1 Tes | formed? 2 No | death? | 2 10 No |
| of Vital | \$ s = 0 | To Be | examiner? | Hospital: | ent 2 ER | VOutpatient | 3□ DOA i Oth | 05 | f Death Check only ing Home 5 Res | | ther (Specif | (v) |
| | | | 27. Manner of Death 1 ☑Natural 5 ☐ Pend | 28a. Date of Inju | iry 28 ly Year) | b. Time of Injury | 28c. Injur Wor | | | how injury occ | | <i>''</i> |
| Division | ten leat tor: | ficati | 3 ☐ Suicide 6 ☐ Coul | | iury - At home | a farm stree | | Yes 2 No | | (Street and Nu | mber or Rus | al Route Number. |
| Οį | s after s after al Dire ed in b | Certification: | 4 Hamicide | building, et | c. (Specify) | ,, | .,, | | City or To | own, State) | | arriodio ridingoi, |
| | To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by | Medical | Check only 2 Medica | ying Physician: To the best al Examiner: On the basis o | of examination | idge death e and/or inve | ocumed at the to | no data and pinion, death | place, and due to the occurred at the time | caues(e) and , date and plac | e, and due to | tated. o the cause(s) |
| | ro the vithin 2 of the comple | Med | one) 29b. Signature and title of certif | and manner st | ated. | | 29c. Licens | e number | | 29d. Date sign | ned (Month, | Day, Year) |
| | . > - 0 | | Danie | 1 A | MD | | AS | 2438 | 528 | Noven | nher | 27 -210T |
| | 10 | 1 8 | 30. Name and address of perso | on who completed cause of o | | | rint) | T) | 1/2 | | | 27-2005 |
| | Sta | ate | DANLEL AB) 31. Date filed (Month, Day, Yea | ar) 32. Regist | 900 rar's Signature | <u>Cato</u> | n Ave | -, B | Utimere | , MO | 2/0 | XXY |
| - | Regist | | MOV 2 | 9 2005 | ue l | 4 6 | est? | | | - | | |

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

38204 State of Maryland / Department of Health and Mental Hygie $\Re \Omega = 0.05$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MILDRED L. HARRIS 24 11.25 2005 /Medical November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTINOR
If Under 1 Year If Under
Months Days Hours SINAL HOSPITAL

5. Social Security Number 6. Sex OF BALTIMORE
7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) (D · 28 · 1940 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 216.36.4251 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Modical Examiner must be notified at MD Baltimore 1 MYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Heights Avenue or iteme 23a or 3908 Libertu 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 X No Yes, Give 1 Never Married 2 Married Black 1 ☐ Yes 2 KNo Specify: ģ 3 Widowed 4 Divorced Year or Dates: "natural" permit. Pages 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event any injury or other traumatic event. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) IBM Clerk 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Coifield Jimmie Estella Vesler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Liberty Heights Avenue Parker 3908 Husband Barbo. MD 21207 Douglas Pa 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11.30.05 Baltimore MD Stav Western 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service hicensee 23 Name and Address of Facility Vaughn C. Greene Funeral Services 515NBaltimore National Pike Balto MD 21729 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Small lung Cancer Metagratic Cell Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. or Attend after death Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Srivasaui. K RES-000 Movember 24 9005 impleted cause of death (Item 23a) (Type, Print) 3 SRIVBSAULK.CHACTANTI NT MO S 32. Resistrar's Signature SINAL HOSPITAL OF BALTIMORE. 31. Date filed (Month, Day, Year) State NOV 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene () () 5

1- State of Maryland / Department of Health and Mental Hygiene () () 5

Registrar Registrar Registrar 38205 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea NOVEMBER 22,2005 **Physician** Melva Henderson 5:07 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NORTHWEST REGIONAL HOSPITAL RANDALLSTOWN BALTIMORE CO 5. Social Security Nu**795**2 215 · LeO · 7552 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year OA · O(·) 7. Age (In yrs. iast birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 ☐ M 2 XF 53 Yrs. MD Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examinar must be notified at MD Baltimore 1 XYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ane USA Tucker 21207 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 KNo 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced al Hygiene. d other then "nature event, It e Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assidant Health Assistant NA 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill thent of Heelth and Mental H tant: If item 27 is marked other. Be Young Donelia James Goldston 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relatio (Type, Print) 34 Janjer Court Gwinn Oak MD 21207 Wendi Watkins Daughter permit. Pages 1 and Depertment of Heelth Important: if tiem 27 eny injury or other troone. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 30Pate 1 Burial 2 Cremation 3 Removal from State Greenmount 11 29 05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se vice Licensee 22. Name and Address of Facility
Voughn C. Greene Funeral Senices
5151 Baltimore National Dike Balto MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Carolio De 1er **Physician** SHE resulting in death) /Medical (br as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown sete hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of d, ath? certificete Yes 2 No the Hospitel or Attending Physician: : After this certifical funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 No Hospital: 1 Inpatient Other: 4 \(\triangle \text{Nursing Home} \) 5 \(\triangle \text{Residence} \) 6 \(\triangle \text{Other} \((Specify) \) 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ within 24 hours after To the Funeral Direct 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Sio a ur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME NOVEMBER 23, 2005 Name and address of person who completed use of death (Item 23a) (Type, Print) NO 111 PENN STREET, BALTIMORE, MARYLAND, 21201 OL 31. Date filed (Month, Day; Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene or

| | | Cen | tificate of Death | Reg. No | 005 3 | 8200 | | | | | |
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| | | 1. Decedent's Name (First, Middle, Lest) | | 2. Date of Death | | 3. Time of Death | | | | | |
| | Physician | Robert E. Haar | | November De | 24, 2005 | 2:25 AM | | | | | |
| | /Medical Examiner | 4a Fecility Name (If not institution, give street end number) | 4b. City, Town, or Lo | ocation of Death 4c | . County of Deeth | | | | | | |
| | | St. Elizabeth Rehab Nursing Center | Baltimo | | | | | | | | |
| | Funeral Director | 5. Social Security Number 215-07-7277 6. Sex 1 7. Age (In yrs. last birthday) 96 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 21, 190 | 9 Birthpl Count 19 Penns | ace (State or Foreign try) Sylvania | | | | | |
| | permit, Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "naturel", or items 23s or 23s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc | ation | | 10 | Od. Inside City Limits | | | | | |
| | | Maryland Baltimore | | | | 1X Yes 2 □ No | | | | | |
| | ifer deeth with the Mai r Items 23s or 28s-f si piner must be notified Funeral Director | 10e. Street end Number | 10f. Zip Code | 10g. Cit | itizen of Whet Coun | try? | | | | | |
| | th with 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st of 23st o | 3320 Benson Ave. | 21227 | | ISA | | | | | | |
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| Maryland 21215-0036 | ed within 72 hours afte ygiene. The maturel; or if it, the Medical Examinat, the Medical Examination Completed by Fig. | 3 XWidowed 4 ☐ Divorced Year or Dates: | ☐ Yes 2 🖾 No Specify: | | open, | nite | | | | | |
| 5-(| natu | 15. Decedent's Education 16e. Decede (Give kinds) 15e. Decede (Give kinds) 15e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kinds) 16e. Decede (Give kin | ent's Usual Occupation kind of work done during most of work PO NOT use retired) | ring 16b. K | Kind of Business/Ind | lustry | | | | | |
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| 9 | Hygid Hygid | 17. Fether's Name (First, Middle, Last) | 18. Mother's Nam | e (First, Middle, Maider | n Sumame) | | | | | | |
| an | Mental H Mental H srked ott stic ever | Miller E. Hoar | E11a C | . Wise | | | | | | | |
| ary | 2 should be f and Mental I is marked of raumatic eve To Be | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing | g Address (Street and Number or Rui | ral Route Number, City | or Town, State Zin | Code) OW_Street, | | | | | |
| | and 2 salth a n 27 is | Ralph W. Coho, Jr. Law 300 W | illow Valley Lake | s Dr. Apt | D-304 PA | 1/584 | | | | | |
| Baltimore, | Pages 1 and 2 nent of Health s ant: if Item 27 is ury or other tra | 20a. Method of Disposition 1 □ Burial 2 ဩ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Cre | | | ocation - City or To Catonsvill | | | | | | |
| alti | permit. Page Department of Important: if any injury or once. | 21. Signature of Funeral Service License | Name and Address of Facility Home | of Catons | ville, Ir | ıc. | | | | | |
| 0 | 82 = 8 | | 30 Edmondson Ave. | | 11e, MD 2 | 21228 | | | | | |
| | | 23a. Part1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. | r the mode of dying, such as cardiac | or respiratory arrest, | | Approximate Interval Between Onset and Death | | | | | |
| | Physician | A. | 1 + 1 | -/ | | Onset and Death | | | | | |
| 4 | /Medical Examiner | Immediate Ceuse (Final disease or condition resulting in death) a. Canglelive figure facultie | | | | | | | | | |
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| × | The law requires that the death certificete be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit. | Sequentially list conditions, if env. leading to immediate | uence of): | / | | | | | | | |
| 68760, | sician buria | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events | tongo of): | | | | | | | | |
| 687 | ficete be g physicis as the bur ledical | resulting in death) Lest Due to (or as e consequence) | leffce of y. | | | | | | | | |
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| | at the death cer d by the attendir leteched for use Physician/A | Part II. Other eignificent conditions contributing to death but not resulting in the un | derlying cause given in Part I. | 23b. Did tobecco | o uee contribute to | the cause of death? | | | | | |
| P.0 | d by the effects | Hypostousion | | 1 □ Yes | 2☑No 3□Prot | bably 4 Unknown | | | | | |
| Ś | signe d be o | | 1 - | 24a. Was an auto | onsy 24b. We | ere eutopsy findings | | | | | |
| Records, | The law requires that the death cerse has been signed by the attendire page 2 should be deteched for use Completed by Physician/A | - Cereleio Vas Cular | Accident | performed? | ava | ailable prior to mpletion of cause death? | | | | | |
| æ | e has | | | 1 ☐ Yes 2 | 2 No 1 C | ∃Yes 2□No | | | | | |
| Vital | slan: T | 25. Was case referred to medical | 26. Place of Dea | th (Check only one) | | | | | | | |
| Ž | Physician: this certific ral director, | examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatien | | ome 5 Residence | 6 □Other (Specifi | y) | | | | | |
| n of | ng Ph fter th ineral | 27. Menner of Deeth 1 ✓ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how inju | ury occurred | | | | | | |
| sio | Attending in death. actor: After by the fune | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, structure 2.5e. | M 1 Yes 2 No | 28f. Location (Street a | and Number or Rura | il Route Number. | | | | | |
| Division | effer of Direct of in by | 4 Homicide determined building, etc. (Specify) | set, factory, office | City or Town, Stat | | | | | | | |
| | To the Hospital or Attending Physician: The is within 24 hours effer death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com | 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth 2 Medical Examiner: On the basis of exemination end/or invariant manner steted. | occurred at the time, date end place, restigation, in my opinion, death occur | , and due to the cause(s rred at the time, date an | s) and manner as st nd place, and due to | tated. the cause(s) | | | | | |
| \ | To the within To the comple | 29b. Signature and title of certifier | 29c. License number | 29d. D | ate signed (Month, | Day, Yeer) | | | | | |
| | OXI | 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, I | Print) | | 0/00 | 223. | | | | | |
| | 1,4, | RANIS. KARIPINENI 202 W. | MAPLERD, a | LINTHICI | UM, ML | 21090. | | | | | |
| | State | 31. Dete filed (Month, Day, Year) 32. Registrer's Signature | soule | | | | | | | | |
| | Registrar | NOV 2 9 2005 Kings & A | П | | | | | | | | |

DHMH 16 Rev 6/95

ORIGINAL

| | 1- State of Maryland / Department of Health an Certificate of Death | nd Mental Hygien Rog. R | 71115 38711 <i>1</i> - |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------|
| Physician | 1. Decedent's Name (First, Middle, Last) Richard A. Hall | 2. Date of Death | 3. Time of Death 19 2005 11:37 .M. |
| /Medical Examiner | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of E Baltimore | Death 4 | c. County of Death |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 | | 9. Birthplace (State or Foreign Country) Maryland |
| ow ow | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits |
| vith the Man, to 28s-1 sh | MD Baltimore Catonsville | | 1 □ Yes 2 🛣 No |
| h with the 23s or 2 | 10e. Street and Number 10f. Zip Code 21228 | 10g. C | Ditizen of What Country? USA |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if tien 27 is marked other than "natural; or items 23a or 28a-1 ehow eny injury or other traumatic event. In Medical Evandination and once. To Be Completed by Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 | 1? (Specify Yes or No- Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White |
| Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Marial Hygiens. In myortant: if item 27 is marked other than "natural", or my injury or other traumatic event. Ita Madical Exarta Dice. To Be Completed by F | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ 16a. Decedent's Usual Docupation (Give kind of work done during most of life. DO NOT use retired) Teacher | of working | Kind of Business/Industry Education |
| and the be filed by the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before the before th | | s Name (First, Middle, Maide | en Sumame) |
| Maryla 12 should I h and Men 7 is marke traumatic | 19a. Informant's Name/Relationship (Type, Print) Hazel Hall —wife 6637 Frederick Rd. | | |
| nore, lages tan ont of Healt tiff item 2 y or other | 20a. Method of Disposition 1 \(\mathbb{D}\) Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{R}\) Removal from State 4 \(\mathbb{D}\) Donation 5 \(\mathbb{D}\) Other (Specify) 3 \(\mathbb{R}\) Removal from State 4 \(\mathbb{D}\) Other (Specify) 4 \(\mathbb{D}\) Other (Specify) | Date 20c. | Location - City or Town, State |
| Baltir permit. P Departme Importan eny injur | 21. Signature of June and Address of Faculty Witzke Funeral | Home of Cator | |
| Physician /Medical | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | Approximate Interval Between Onset and Death |
| cate be executed physicien end it the burial-transit circle Examiner | Sequentially list conditions, limb cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | |
| certific | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown | | 23d. Date of delivery Month Day Year |
| S, S, S, S, S, S, S, S, S, S, S, S, S, S | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacce 1 ☐ Yes | o use contribute to the cause of death? 2 No 3 Probably 4 Winknown |
| Hass has | | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| of Vital Forbysician: The scartificate ral director, page 170 Be Col | examiner? | of Death (Check only one) | |
| Vision of Vatending Physical directions of the funeral direction of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o | 1 Yes 2 No | sing Home 5 Residence 28d. Describe how in | |
| Division control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, ate) |
| Divisid Divisid To the Hospital or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the Medical Certifical | 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death and manner stated. | occurred at the time, date a | and place, and due to the cause(s) |
| To the within To the common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common co | 29b. Signature and title of certifier / 29c. License number | | Date signed (Month, Day, Year) Ovember 19,2005 |
| 541 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Henggeler MD; 900 Caton Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature, | | |

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 20, 2005 Debra A. Hartsell 6:34 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital NA Good Samaritan Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2√x 218-62-0859 51 Yrs. Director 9-11-1954 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28e-f ehow 1 ☐ Yes 2 ☐ No Baltimore Maryland Parkville Directo 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 8003 Jacqueline Lane 21234 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 Yes 20XNo Specify: δ white 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatic event, the Medica. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 In own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Calvin Earl Martin Nancy Parks 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rashel C. Eakins Daughter 126 Ludlow Drive Wilmington, NC28411 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11/25/2005 Catonsville, MD 21. Signature of Funeral Service Ucen 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Respiratory Failure
Due to (or as a consequence of): **Physician** /Medical Examiner epsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit Attending Physician: The law requires that the death certificate be executed 6211 Carcinoma Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Tilnknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes r; After this certifica e funeral director, p 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funerei Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after or To the Funerel Direc determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 22, 2009 M.D Res-000 Journay 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Bird Baltimore MD 21234 Somuath Chosh 5601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 38209 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:35 AM Virginia Wellham Hubbard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health at Glen Burnie Anne Arundel Glen Burnie Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9/06/1924 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 200 Yrs Director 81 215-30-1719 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or Items 23a or 28s-f show event, the Medical Examinar must be notified at 1 ☐ Yes XXNo Linthicum Directo MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21090 USA 424 Forestview Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) al Hygiene. Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental Item 27 is marked o Ida Virginia Shipley George Wilson Wellham 2 other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linthicum, MD 21090 424 Forestview Road, Mr. William N. Hubbard / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 11/29/05 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. SW Glen Burnie, MD 21061 SW ask W. MO1357 1 Second Avenue, 23a. Part1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 1 A) FORETTUAL Physician MYOCARDI AL /Medical resulting in death) Due to (or as a consequence of): Examiner CAMPIOURS (ULIM 7MINOSCLIMOTIL S - uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 11111179517 Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physicien Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 □Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed?

1 Yes 2 70 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 21 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 24 hours after death.

Funeral Director: A 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 THomicide filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) NOVEN352 28, 027838 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,518 CAMP MRMINGO, LINITH OUN 77.0 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEAS S Registrar

9 2005

| | | • | For State Registrar | State | of Marylan | | artment tificate | | | | | giene Reg. Ho. | 15 | 38210 |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------|----------------------|---------------------------------------|-------------------------|-----------------------------------------|---------------------|-------------------|----------------|-----------------------------------------|------------------------------|---------------------|----------------------------------------------------|
| I | Dhymini | | 1. Decedent's Name (First, Middle, L | ast) | | | | | | | 2. Date of Dea | ath Day | Year | 3. Time of Death |
| | Physicia /Medic | | Anna Vera Margar | | | enders | | | | | Novembe | r 25, | 2005 | 2:00 A M |
| | Examin | er | 4a. Facility Name (If not institution, gi | | | | | | Location of | | | | ty of Deat | |
| | | | Wilson Health Ca | | | | | | ersbu | | | | | omery |
| | Funeral | | | Sex 1 □ M 21XT F | 7. Age (In yrs. | 93 Yrs. | Months | Days | If Under Hours | Min. | 8. Date of Birl (Month, Da May 24 | h y, <i>Year)</i> 1012 | 9. Birtl | hplace (State or Foreign untry) linois |
| | Director | | 360-30-5932 Usual Residence of Decedent | | | 1,3. | | | | 1 | may 24 | 1912 | 11. | IIIIOIS |
| | land ow | | 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | Man | ţ | Maryland Montgo | merv | | | Gait | her | sburg | o _r | | | | 1 X Yes 2 ☐ No |
| | r 28e | irec | 10e. Street and Number | | | | 10f. Zip | | Dour | 5 | | 10g. Citizen of | What Co | ountry? |
| | h wit | | 739 Tiffany Dri | ve | | | | 2 | 0878 | | | United | Sta | tes |
| | deat | Funeral Directo | 11. Marital Status | | edent Ever in U. | .S. 13. | Was Deced | ent of Hi | spanic Ori | rigin? (Spe | cify Yes or No Rican, etc.) | - 14. Ra | ace - Ame | nican Indian, |
| စ္က | or its | Fu | 1 ☐ Never Married 2 ☐ Married | 1 ☐ Yes If Yes, G | 2 XNo | - | 1 □ Yes 2 | | | | , | Spec | T 71 | nite |
| ğ | within 72 hours after death with the Maryland ene. ttan "tetural", or Itams 23e or 28e-f show tra M. Jical Ext. rifer mant be notified at | d by | 3 XWidowed 4 Divorced | Year or [| Dates: | 1 | | | | | | | | |
| 7 | "nat | Completed | 15. Decedent's 1 (Specify only highest g | |) | (Give | dent's Usua kind of wor DO NOT us | k done a | lurina mos | st of workin | ng | 16b. Kind of | Business/ | Industry |
| 12 | withir ene. than | m d | Elementary/Secondary (0-12) | College (| 1-4or 5+) | ,,,,, | Home | , | | | | Own H | ome | |
| 2 | filled Hygi othar ant, I | | 17. Father's Name (First, Middle, Las | t) | | .1 | Homes | IIIIII | | er's Name | (First, Middle, | Maiden Suma | | |
| an | iould be filed within I Mental Hyglene. Parked other than tatic event, Ine M | To Be | David Beveridge | | | | | | Ret | tsv S | kinner | | | i |
| Maryland 21215-0036 | 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or litems 23e or 28e-1 show aumatic event, if a Marilical Examiner mant be multiled at | - | 19a. Informant's Name/Relationship | | | 19b. Mailir | ng Address | (Street a | | | | er, City or Town | n, State, 2 | Zip Code) |
| | 1 and 2 Health a tam 27 is | | Nancy Skinner/Da | ughter | | 739 T | iffan | y Dr | ive, | Gait | hersbu | rg, Mar | ylan. | d 20878 |
| altimore, | ges 1 and or other | | 20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 | □ Bomovel from | 20b. P | Place of Disponentation | sition (Nam | ne of ther place | e) 1 | Novemb | er26. | 20c. Location | - City or | Town, State |
| Ĕ | Pages nent of I ant: If its ury or o | | `4 □ Donation 5 □ Other (Spec | | C: | remato | rium, | Inc | | 20 | 05 | | | aryland |
| at | permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 is marke any injury or other traumatic <u>once.</u> | | 21. Signature of Forneral Service Lic | nsee | | 22 | 2. Name and | d Addres | s of Facili | Robe | rt A.] | Pumphre | y Fu | neral Home/ venue |
| <u> </u> | 20529 | | 1 CORE | titi |) MO13 | | | | | | | | Ly A | venue |
| n, | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | y one cause on | each line. | | | , | | | | rrest, | | Approximate Interval Between Onset and Death |
| ď | Priysician | 4.7 | Immediate Cause (Final disease or condition resulting in death) | a. 40 | ult | Jais | lus | 210 | 3 1/6 | n | ne | | | Onsot and Death |
| B | /Medical Examiner | | resulting in death) | Due to | (or as a conse | (ence of): | , | ~ 4 | 103 | | | | | |
| | | ā | Sequentially list conditions, if any, leading to immediate | b. Due to | (or as a conseq | uence of). | 40 | er | CE | e | | | | |
| | uted d ansit | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | |
| ó | an an rial-tr | Exa | resulting in death) Last | Due to | (or as a conseq | juence of): | | | | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit | cal | • | d. | | | | | | | | | | |
| တ | leath certifica attending pt I for use as t | Physician/Medi | IF FEMALE: | | | | | | | | | | | |
| Вох | ath ce | lan/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live | utcome of pregna birth 2 - Feta | ıl death 3 | Ectopic pro | | | | | | ate of del Jonth | ivery Day Year |
| | the a | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4∐Preg 9☐ Unki | nant at time of d | leath 5 | Other (sp | өсіту) | | | | | | |
| ď. | that the ed by detact | h h | Part U. Other significant conditions | contributing to | death but not res | ulting in the u | nderlying ca | ause give | en in Part I | l. | 23e. Did t | obacco use co | ntribute to | the cause of death? |
| Records, | requires that the death cer been signed by the attendir should be detached for use | Completed by | Dialietes | nru | lend | yer | rde | nt | | | 1 🗆 ' | Yes 2☐No | 3 🗆 Pr | obably 4 Unknown |
| 000 | s bee | siete | Lyperter | rsii | n A | Ceppe | Wil. | id | en | ria | 24a. Was | | . Were au | itopsy findings available |
| | ician: The lav certificate has ector, page 2 | m o | Anemia | , | | 1/ | V | | | | autor perfo | rmed2/ | death? | completion of cause of |
| Vital | | a | 25. Was case referred to medical | | | | <u>-</u> | | 26. Place | e of Death | (Check only o | | 103 | 2010 |
| | Physical this cer al direc | To B | examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 | Inpatient 2 | ER/Outpatie | nt 3□ D0 | A Othe | er: 4 1/10 | ursing Hon | ne 5 🗆 Resi | dence 6 🗆 O | ther (Spe | cify) |
| 0 0 | tanding Physician: The feath. tor: After this certificate hi the funeral director, page | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date (Mo | of Injury nth, Day Year) | 28b. Time o | 1 2 | 8c. Injury Work | y at k? | 2 | 28d. Describe | how injury occi | urred | |
| Sio | death. ctor: A | catic | 2 Accident investigat | on | | | М | | Yes 2□ | - | | | | |
| Division of | i or Attano after deatl Diractor: I in by the | Certification: | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | 200. Flat | e of Injury - At hiding, etc. (Specif | ome, farm, st fy) | reet, factory | , office | | 2 | 28f. Location (City or To | | nber or Ru | ural Route Number, |
| | | | 29a. Certifier 1 P Certifying | Physician: To " | e best of my kno | nwledne dost | h accuract | at the ti- | no data a | and place of | and due to the | cause(s) and | manner c | stated |
| | 24 hos Fun | edlcai | (Check only 2 Medical Ex | aminer: On the | | | | | | | | | | |
| | To the Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by | Me | 29b. Signature and title of certifier | | | | 290 | . License | e number | | | 29d. Date sigr | ned (Mont | h, Day, Year) |
|) | ~ | / | 1 H. Rolleri | Bur | whle | nell | d | DO4 | 115 | | / | Vener | ne | 1.25,2005 |
| 1 | 11 | | 30. Name and address of person wh | | | | | | | | | | | |
| V |) | | Robert H. Birsch | | # | | 211 Av | renue | e, Ga | aithe | rsburg, | Maryla | and 2 | 20877 |
| | Sta Regist | | 31. Date filed (Month, Day, Year) NOV 2 9 | | Registrar's Signa | IN AS | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 400 an Boz 28,200 6:30 AM OHN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO MA FRODERICK UILLA NURSING CINITIC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-20-1934 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 2M 2 F 220-30-5198 Director MARI LAND Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. worle 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "natural", or items 23e or 28e-f ehov treumatic event, the Madical Examinational be multified at 1 3 Yes 2 No BALTO Director mo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21207 5904 USA TRADU Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLHCK þ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B. MORTON + SONS ABORER -8 -0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) M. HICKS CON 2 ouise 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MD. Z1207 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cemation 3 Removal from State 12-2-2005 BALTO ZION 4 Donation 5 Othe (Specify) N. MONROE ST. BALTO, MD 22. Name and Address of Facility Rep D 21. Signature of Fy any ir 1721-27 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lax disease or condition resulting in death) Vareu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an page 2 autopsy performed 2**(**) No 2 0 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation within 24 hours after used...
To the Funerel Director: 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO0 6353c NO Vember 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahba saltimore, MD Nandana 31. Date filed (Month, Day, Year) 32. **S**gistrar's Signature State NOV 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie \mathfrak{p} 0 0 5 38212 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21) am Frederick Charles Irvin November 24, 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Maryland G. 5. Social Security Number Ceneral ober 6. Sex Batimore Lity
If Under 1 Year If Under 24 Hrs. Hospita 8. Date of Birth (Month, Day, Year) Oct 8, 192 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1X M 2□F 83 178-16-2466 Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Mcdical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5803 Larsen Street 21061 **USA** filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 1942 If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specity: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Electronics other than Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician Manufacturer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o Frederick A. Irvin Hazel Irene Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia C. Irvin, Wife 5803 Larsen Street Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/25/05 Metro Crematory Inc. ⁴ 4 □ Donation Baltimore, Maryland 21. Signature Funeral Service License ²² Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 any ii George E. MacNabb Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician orban Diexide /Medical Due to (or as a consequence of): Examiner Dua to (or as a spheequence of): HATTERY Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy jo Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospitat or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NWACHUKWU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Itherra Nwachukwun 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

| | | | | State of Maryland / Department of Health and National State of Maryland / Department of Health and National State of Beath State of Death | Mental Hy | giere 0 0 5 | 38213 |
|---------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------|-----------------------------------------------------|
| | | | | 1. Decedent's Name (First, Middle Last) | 2. Date of De | eath | 3. Time of Death |
| | | Physicia /Medic | | LRUIN KOHAL JOHNSON | Month | Day Year 21 200 | 5 11.30 PM |
| | | Examin | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | 4c. County of Dea | th |
| | | | | 6. Secial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | | dh 0 Bi | thplace (State or Foreign |
| | П | Funeral Director | | 5. Social Security Number 6. Sex 12M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. | Month, D | ay, Year) | ountry) T VIRGINIA |
| | | g | | Usual Residence of Decedent | 1// | 7707 702. | |
| | | show | 7 | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| | | the M | Director | 10e. Street and Number 10f. Zip Code | | 10g. Citizen of What C | |
| 7 | | death with the Maryland ms 23a or 28a-f show rmast be notified at | Dir | 706 HICHWOOD DR. 21212 | | ()54 | HAZT I |
| Co | | death | Funeral | 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St | pecify Yes or No | 0- 14. Race - Am | erican Indian, |
| 2 | 9 | after or Ite | / Full | 1 Never Married 2 Married 1 Yes 2 No | o Hican, etc.) | Specify: | le, etc. |
| 3 | 215-0036 | be filed within 72 hours after death with the Marylar ital Hygiene. od other then "naturat", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | d by | 3 Midowed 4 Divorced Year or Dates: | | W | HITE |
| 0 | 5. | in 72 n "na fedic | Completed | 15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired] | king | 16b. Kind of Business | rindustry |
| () | 212 | d with giene er the | E O | Elementary/Secondary (0-12) College (1-4or 5+) DIESEC MECHANIC | | AUTOMOT | TUE |
| | | be file tal Hy d oth | Be (| 17. Father's Name (First, Middle, Last) | | , Maiden Sumame) | |
| .\$ | Maryland | 2 should be filed with and Mental Hygiene. Is marked other thei eumatic event, that | 2 | | THY | MRK | |
| 3 | Mai | D = - = | 1 | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru. 7303 PARK DRIVE | マレ | | |
| <u></u> | ē, | permit. Pages 1 and 2 should Department of Heelth and Men Important: If item 27 is marke any injury or other treumatic once. | | 20a Method of Disposition 20b. Place of Disposition (Name of | Date | 20c. Location - City or | |
| 1-1 | altimore, | Pages nent of I int: If it | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Commetery, crematory or other place) Nove Cond Shepholo Cem 25, | EMBER | ELLICOIT | CITY, MD |
| | | permit. Departm Importa any inju | | | - | FUNERAC | CHAPEC |
| | 8 | 89789 | | 1/14 to BSCL 8800 HARFORD K | 20. K | | 10 21234 |
| _ | | | | 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. | or respiratory a | arrest, | Approximate Interval Between Onset and Death |
| | | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. End stage COPD | | | |
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| | 50, | cate be executed physician and the burial-transit | | resulting in death) Last Due to (or as a consequence of): | | | |
| | 8760, | physic physic | dicai | d | | | |
| | 9 xc | eath certific attending p | л/Ме | IFFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | 23d. Date of de | livery |
| | ğ. | Physicien: The law requires that the death certific this certificate has been signed by the attending Ir this certificate has been signed by the attending Ir all director, page 2 should be detached for use as | Physician/Me | in the past 12 months? 1 | | Month | Day Year |
| | 0 | that the dended by the a | hys | 9 ☐ Unknown 9 ☐ Unknown | | | |
| | S, | w requires that been signed to should be deta | by | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | tobacco use contribute t | o the cause of death? robably 4 Unknown |
| | oro | requi | eted | Caralac arryrhmia | - | | |
| | Rec | sicien: The law certificate has t irector, page 2 s | Completed | | 24a. Was auto | | utopsy findings available completion of cause of |
| | la | ificate | e Co | 25. Was case referred to medical 26, Place of Deal | 1 Yes | 2 No 1 ☐ Yes | 2 □ No |
| | > | ysicien: is certific director. | 0 8 | examiner? | | idence 6 Other (Spe | icity) |
| | n o | ttending Phys death. stor: After this c | T :uc | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury Work? | | how injury occurred | |
| | Siol | eath. or: Al | catic | 2 Accident investigation M 1 Yes 2 No | | | |
| | Division of Vital Records, P.O. Box | or Atl after d Direct in by | Certification; | 4 Homicide determined determined determined determined determined determined determined determined determined determined determined determined determined | 28f. Location (City or To | (Street and Number or R wn, State) | ural Route Number, |
| | | spitel | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, | and due to the | cause(s) and manner a | s stated. |
| | | n 24 h | edicai | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. | red at the time, | date and place, and due | to the cause(s) |
| | | To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funera | Σ | 29b. Signature and title of certifier, 29c. License number 8 F S O O O | | 29d. Date signed (Mon | |
| | • | 10 | | 47 | 1. | November 2 | |
| | ĺ | 5 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Schooliter INDRANI MUKITEN JEE 56 CL Loch Rowen Boulever | d Balk | al. | 217 29 |
| | | Sta | ite | 31. Date filed (Month, Day, Year) 32 (1.5 strar's Signature | | | -21 |
| | | Registr | | 31. Date filed (Morith, Day, Year) 32 Astrar's Signature (MOV 2 9 2005 | | | |

DHMH 17 Rev 1/2001

Kevin Daniel James Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 07921CT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** November 2005 2:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Providence Road Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 215-82-5725 Usual Residence of Decedent 1 M 2□F Director 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23s or 28s-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo IIMor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 2⊠ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use regired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COMMUNICATION Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 1 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or lown, State permit. Pages 1
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important: if ite
eny Injury or ott 1 Burial 2 Cremation 3 ☐Removal from State 2005 4 ☐ Donation 5 ☐ Other (Specify) orest Hil 22. Name and Address of Facility EVANS 21. Signature of Funeral Service Licensee Del Cha memores O 101 Parkville ra. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple INTURIES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Day 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown nere! Director: After this certificate has been signed filled in by the funeral dire tor, page 2 should be de-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 275 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence XXOther (Specify) Scene မ 1XXes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural :35 A 1 ☐ Yes 2 X No 24/05 investigation Driver in autolthee impact 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 025 Provide Rund 4 ☐ Homicide Providence Rund within 24 hours a To the Funerel L 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) OCME November 24, 2005

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month-Day, Year)

JAIK M.

ORIGINAL

111 Penn Street

Baltimore, Maryland 21201

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

| | | 1 - For State Registrar | State of Maryland | | artment of tificate of | | | giene | 005 | 382 | 15 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------|--------------------|-----------------------------------------|-----------------------|-------------------------------------------------------------------------|--------------------------------------------|----------------------------|
| Physic /Med Exam | lical | Decedent's Name (First, Middle, Last) Kathleen 4a. Facility Name (If not institution, give s | Marie James | 1 | 4b. City, Town, | or Location of Dea | 2. Date of De Month Novemb | er 2 | Year 4, 2005 County of Death | 3. Time of 6:00 | Death A M |
| Funera Directo | l e | 10 N. Symington A | venue | ast birthday) Yrs. | If Under 1 Yea Months Days | Catonsvi | 11e s. 8. Date of Bir | th | Baltin 9. Birth | | r Foreign |
| Be-f ehow | ctor | Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo | | , Town or La | | consville | | | 10d. Inside City Limits 1 Tyes 2 No | | ty Limits |
| ite, Initially inition of IAI 13-0030 It and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28e-f show other traumatic event, the Medical Exacts arms to another and its and the statements. | ted by Funeral Director | 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ | 2. Was Decedent Ever in U.S Armed Forces? 1Yes _2 _XNo If Yes, Give Year or Dates: | 16a. Dece | Was Decedent of Yes, specify Cu | ination | |)- | USA 14. Race - Ameri Black, White, Specify: Ind of Business/In | can Indian, etc. White | 307 - 114 ₀ Swe |
| ial yialiw K. K. 19 2 should be filed within 7 and Mental Hygiene. Is marked other then "n aumatic event, tra Media | Be Completed | (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) | College (1-4or 5+) | life. | kind of work done NOT use retir | cialist | orking ame (First, Middle) | Soc: | ial Secu inistrat | rity | |
| d 2 s th ar th ar trau | To E | Michael J. Eick 19a. Informant's Name/Relationship (Tyx) Earl E. James/Hush | · | | | and Number or F | | er, City or | r Town, State, Zij | - / | |
| Dallillore, IN permit. Pages 1 and 2 Department of Health Important: If Item 271 eny Injury or other tra | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) | amoval from State Cres | ace of Dispo emetery, crer stlawn | sition (Name of natory or other pl | 1 11 | Date /28/05 | 20c. Lo | cation City or To | own, State | MD |
| Dermit Depart Import | | 23a. Part1. Enter the disease, or complice | orchik cations that caused the death | 3 | | rick koa | | svill | al Home, Le, MD 2 | 1228 Approximate | ө |
| Physician /Medica Examiner | | shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. | Due to (or as a consequ | ence of): | NCER | | | | | Interval Bety Onset and E | veen)eath |
| ate be executed hysicien and the burial-transit | dical Examiner | Sequentially list conditions, and, leading to initial dialactions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequ | | | | | | | | |
| The Colids, T.O. BOX 00/00, The law requires that the death certificate be executed at has been signed by the attending physicien and page 2 should be detached for use as the burial-transil | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | ac. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetat 4 □ Pregnant at time of de 9 □ Unknown | death 3[| Ectopic pregnant Other (specify) | су | | 2 | 23d. Date of deliving Month | - | /ear |
| w requires that been signed b | ۵ | Part II. Other significant conditions con | tributing to death but not resu | ilting in the u | nderlying cause g | iven in Part I. | | | se contribute to t □ No 3 □ Prot | | |
| ian: The law rifficate has b | e Completed | 25. Was case referred to medical | | | | 26 Plage of De | | osy ormed? 2 No | 24b. Were auto prior to co death? 1 \(\subseteq \text{Yes} \) | opsy findings a emptetion of ca 2 No | available ause of |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director; page 2 is | atlon: To B | examiner? 1 Yes 2 No H 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation | | ER/Outpatier 28b. Time of Injury | 28c. Inju | ther: 4 🗆 Nursing | Home 5 PResident 28d. Describe | dence 6 | | (y) | |
| pital or Atta burs after de aral Directo | Il Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At hor building, etc. (Specify, ician: To the best of my know |) | | | City or To | wn, State) | | | ber, |
| To the Hos within 24 ht To the Fun completely | Medical | (Check only 2 Medical Examinone) 29b. Signature and title of certifier | er: On the basis of examinati and manner stated. | ion and/or in | vestigation, in my | opinion, death occ | e, and due to the urred at the time, | date and | and manner as s place, and due to e signed (Month, | o the cause(s) |) |
| 20 | | 30. Name and ad, ess of person who co | mpleted cause of death (Item | 23a) (Туре, | Print) | 06315° | 9 | Nov | rember 2 | 5, 2005 | 5 |
| S Regis | tate strar | 31. Date filed (Month, Day, Year) NOV 2 9 20 | mpleted cause of death (Item 10 10 10 32 degistrar's Signat | ure | cole | , DALTI | VIDICE (| עוט | 41231 | | |

State of Maryland / Department of Health and Mental Hygiege [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 23 2005 **Physician** Mary A. Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GLEN BURNIE BAHimore Washington Medical Center

5. Social Socurity Number 6. Sox 7. Ago (In yrs. last birthday) ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□₹ Director 63 Yrs. 1942 Maryland 212-42-7221 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itame 23a or 28a-f show traumatic event, the Modical Examinar most be notified at MYes 2 □ No Director <u>Maryland Anne Arundel</u> Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8211 Goose Pond Drive 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2CXMarried Specify:Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 11th 0 Nursing Assistant Provident Center Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be ment of Health and Mentalent: if Item 27 is marked James Jackson Eleanor Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9211 Goose Pond Dr. Pasadena, Md. Claude I. Pack (Brother) or other Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Carpenter Hill 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once 11/29/05 Round Bay, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, P.A. West St. Annapolis, Md. 21401 Zavry & Rees Moof83

Wm Reese & Sons Murtua
821 West St. Annapolis
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Dupit (or as a consequence of): **Physician** Hours /Medical **Examiner** Hemonti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and the do use as the burial-transit Due to (or as a consequence)of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month 4☐ Pregnant at time of death 5 ☐ Other (specify) o be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cete hes been signate. page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No funeral director. 25. Was case referred to medicat 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident Injury 5 Pending death. 1 Yes 2 No investigation within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospitei 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signalure and title of certifier D0032744 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burnie MD 21601 Glenn HOSOITOX 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiese 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month KIM November 04:00 AM 500 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner mercy medical Center Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🗹 F 212.98.5857 68 Director Yrs. KOREF Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygisne.
Important: if item 27 is marked other then "natural", or iteme 23a or 28e-1 ehow enty hjury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No MI Funeral Director ALIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code WEST 201H 1218 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 No Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 ₩idowed 4 Divorced KOREAL Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use regired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 AKED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1XV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9.400001 ,04) TARK DLW 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 Burial 2 Cremation 3 Pemoval from State 11.28.2005 FORESI 4 ☐ Donation 5 ☐ Other (Specify) EVANS FIREAL CHAPEL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EACEFUL ALTERNATIVES FINERALAND CREMATION CENTER Timonsium, MD 21093 Nbizzo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) liver failure **Physician** /Medical Due to (or as a consequence of): Examiner nepatitis Sequentially list conditions, any labeling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a consequence of): signed by the attending physicien and dbe detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1∐ Yes or Attending Physician: ours after death. erai Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death | Check only one Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16634 MD November 25, 2005 30.44 me are address of person who completed cause of death (Item 23a) (Type, Print) mercy medical Center, Dept of Medicine CHEN, M.D LINDA 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State Registrar

| | | | For State of Maryli 1 - State Registrar | Cei | tificate of De | aith and ivie eath | | 2º005 | 38218 |
|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------|-----------------------------------------|-----------------------------------------------|----------------------------|--------------------------------------------------------|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) JOHN J. | KRAMER | | | 2. Date of Death Month | Day Yea | 11:58 P M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) | KIGHIDK | 4b. City, Town, or Lo | | NOVEMBER | 26 20 4c. County of D | 105 |
| | LAGITIT | Ģ, | 7901 Laurel Lakes Court Apt. | 414 | Laurel | | | | George's |
| | . Funeral | | | yrs. last birthday) | | f Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Y Apr 29, | | Birthplace (State or Foreign |
| | Director | | 164-32-1629 M 2 F Usual Residence of Decedent | 66 Yrs. | | | Apr 29, | 1939 Pe | ennsylvania |
| | land ow | | | City, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Mary Fr sh | tor | Maryland Prince George's | Laur | el | | | | 1 X Yes 2 □ No |
| | or 28s | Director | 10e. Street and Number | | 10f. Zip Code | | 10g | . Citizen of What | Country? |
| | death with the Maryland ms 23a or 28a-f show rrivest be rivilified at | rai | 7901 Laurel Lakes Court, Apt. | 414 | 2070 |)7 | | USA | |
| | ar deg | Funeral | 11. Marital Status 12. Was Decedent Ever in Agried Forces? | n U.S. 13. V 729195 | Vas Decedent of Hispa yes, specify Cuban, | anic Origin? (Spec Mexican, Puerto R | cify Yes or No- lican, etc.) | 14. Race - A Black, W | merican Indian, hite, etc. |
| 5 | hours after tural, or Ite | by F | 1 □ Never Married 2 □ Moarried 1 1 Yes 2 □ No U 1 1 Yes 3 □ Widowed 4 □ Divorced 1 Year or Dates: 0 1 | 7-09-196 | Yes 2 X No S | Specify: | | Specify: V | ∛hite |
| 21215-0U3b | be filed within 72 hours after death with the Marylan is a Hygiene. de other than "natural; or Items 23s or 28s-1 show other than and seal show avant, the Medical Evander must be rutilied at | ted | 15. Decedent's Education | 16a. Deced | ent's Usual Occupatio | on . , , , . | 16 | b. Kind of Busine | ss/Industry |
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| | filed wi Hygien othar th | Con | 12 | Elect | ronics Ass | | | | Manufact. |
| yland | | Be | 17. Father's Name (First, Middle, Last) Perry Samuel Kramer | | 18 | 3. Mother's Name | | iden Sumame) | |
| _ | shoutd and Men s marke umatic | 2 | 19a. Informant's Name/Relationship (Type, Print) | 19h Mailir | g Address (Street and | Clara | | ity or Town State | a Zin Codel |
| Ma | s 1 and 2 should f Health and Mer itam 27 is marke othar traumatic | | Brigette Jerome, Daughter | 9375 | Kings Gra | | | | |
| <u>o</u> | s 1 ar f Hea itam othan | | 20a. Method of Disposition 20 | b. Place of Dispos | | | | c. Location - City | |
| Ē | Pages nent of int: If it: iry or o | | 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) | * . | matory Inc | . 11/29 | /05 B | altimore | e, Maryland |
| Baitimor | permit. Pages Department of I Important: If its any injury or of | | 21. Signature of Funeral Service Libensee | | Name and Address or remation S 99 Frederic | | | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the disease. | death. Do not enti- | or the mode of dying, s | such as cardiac or | respiratory arrest | e, maryı | Approximate |
| | Physician | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition LUNG CANC) | CD | | | | | Interval Between Onset and Death |
| | /Medical | | resulting in death) a. Librer CARCI Due to (or as a con | | | | | | |
| | Examiner | | Sequentially list conditions. | | | | | | |
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| \$ | and al-tran | Examiner | that initiated events resulting in death) Last C | sequence of); | | | | | |
| 68/6U, | tificate be executed g physician and as the burial-transit | | | , , | | | | | |
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| X Q Q | that the death certificate be executed ed by the attending physician and detached for use as the burial-transit | an/N | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ F | | Ectopic pregnancy | | | 23d. Date of | |
| | e dea he att | by Physician/N | In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown | | Other (specify) | | | Month | Day Year |
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| g, | ires ti signe d be c | | Part II. Other significant conditions contributing to death but not | resulting in the di | idenying cause given i | iii raiti. | | 2 No 3 | v |
| Hecords | | Completed | | | | | 24a. Was an | 1 | • |
| ě | The law ate has b | dux | | | | | autopsy performe | d? death | autopsy findings available to completion of cause of ? |
| VII | (0 | e e | 25. Was case referred to medical | | 26 | 6. Place of Death | 1 ☐ Yes 24 |] No | es 2K No |
| | Physician: this certific ral director, | To B | examiner? 1 ☐ Yes ※ No Hospital: 1 ☐ Inpatient 2 | 2 🗌 ER/Outpatien | | 4 ☐ Nursing Hom | | e 6 □Other (S | pecify) |
| IO L | ter ter | Ju: T | 27. Manner of Death 1 Xalural 5 Pending 28a. Date of Injury (Month, Day Year | r) 28b. Time of Injury | 28c. Injury at Work? | | 3d. Describe how | | |
| <u>0</u> | Attending F ir death. actor: After by the funera | catic | 2 Accident investigation | | M 1 ☐ Yes | s 2 No | | | |
| UIVISION | nl or Attendir after death. I Diractor: Af d in by the fu | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury • A building, etc. (Sp. | At home, farm, street, ecify) | eet, factory, office | 28 | Bf. Location (Stree City or Town, S | et and Number or State) | Rural Route Number, |
| | Hospital 24 hours a Funaral C | | 29a. Certifier 12 Certifying Physician: To the best of my | knowledge death | accurred at the time | data and place, ar | ad due to the saus | o(a) and manner | an stated |
| | To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by | l edical | one) and manner stated. | nination and/or inv | estigation, in my opini | ion, death occurred | at the time, date | and place, and d | lue to the cause(s) |
| | To Con | Σ | 29b. Signature and title of certifier | 1 | 29c. License nu | | | Date signed (Mo | |
| | _ 6 | | my uninas | | MD# 204 | 459 | NO | VEMBER 2 | გ, 2005 |
| | if | | 30. Name and address of person who completed cause of death (ANTHONY ARCENAS, M.D., VAMC, | 50 IRVIN | | W, WASHII | NGTON, DC | 20422/6 | 88 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Registrar's Si | ignature | Soule) | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 38219 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Oeath 3. Time of Death Day **Physician** Nov. 20 2005 12:20 PM Joan Van Auken Kennedy /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Charlestown Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Yrs Director 75 Sept. 5 1930 Michigan 270-26-3509 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f ehow notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number al Hygiene. . other than "natural", or Items 23a or 2 .vent, Ite Mudical Examiner must be r 711 Maiden Choice Lane 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black. White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 5+ Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lewis Cornell Van Auken Loretta Murphy ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or othar tre Fitchburg, MA 01470
Date 20c. Location - City or Town Joseph P. Wagner/son 58 Sawmill Pond Rd., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
eny injury or oth 11/26/05 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD re of Fluneral Service/Light 199 22. Name and Address of Facility Bryan W. Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Rd., Timonium, MD 21093 Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 M No Yea 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ willtilin 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after deam.
To the Funeral Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vierce Cary van arden 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bear & Agarles Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 38220 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Thomas Keeney 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct 1, 192 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**√**M 2□F 216-12-9922 81 Yrs Director 1924 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan end of Health and Mental Hygiene.
Int: If item 27 le marked other than "naturel; or Iteme 23e or 28a-1 show mary or other than "naturel; or Iteme 23e or 28a-1 show may or other traumatic event, the Mudical Exameter must be routilled an N/A XXYes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Roland Avenue USA Apt. 523 21211 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2XXNo Specify: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oil Burner Mechanic Herman H. Fisher 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Thomas Keeney Mary Gerhart 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Joan A. Keeney 3939 Roland Avenue Apt. 523 Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. Lake View Memorial Park 11/28/05 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee ^{22. Name and Address of Facility}
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 48h/5 Immediate Cause (Final disease or condition resulting in death) **Physician** 33 /Medical Due to (or as a consequence of): Examiner pisation reumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Sphain Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Prognant at time of death 5 Other (specify) been signed by the e should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has al director, page 2 autopsy 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 13 € No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 Impatient 2 ER/Outpatient 3 DOA : After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 Yes 2 No 2 Accident I Director: A 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours e To the Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and titler of certifie 29c. License number 29d. Date signed (Month, Day, Year) and and address of person who completed cause of death (Item 23a) (Type, Print) Mamoria M. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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| | | | 1 - For State Registrar | State of Marylan | nd / Depa | artment of F | lealth and | Mental Hyg | gierre 0 0 5 | 38221 |
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| | Physici /Medic | | Decedent's Name (First, Middle, La Paul Haward | | | | | 2. Date of Dea Month November | Day Yes | |
| | Examir Funeral Director | | 4a. Facility Name (If not institution, give 5. Social Security Number 6. S 219-26-7344 | Baltmore Baltmore 7. Age (In yrs. | last birthday) Yrs. | Beltime If Under 1 Year Months Days | ore City | s. 8. Date of Birth | 4c. County of D | eath Sirthplace (State or Foreign Country) ATYLAND |
| 2 | to to | 70 | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | ty, Town or Lo | | | | | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | with the M or 28a-f | Directo | Maryland Carroll 10e. Street and Number 1818 Benedict Rd. | | Westm | inster | 450 | | 10g. Citizen of What | |
| 356 | be filed within 72 hours after death with the Maryland tal Hygiene rd other then "natural", or Itams 23a or 28a-f ahow avent, I'ra Medical Exeminar must be rectified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1, Yes 2 □ No If Yes, Give Year or Dates: | 1 | | | Specify Yes or No- nto Rican, etc.) | U.S.A. 14. Race - A. Black, W. Specify: W. | |
| 21215-0036 | swithin 72 hou jiene. r then "neture the Medical E | Completed by | 15. Decedent's E. (Specify only highest grave Elementary/Secondary (0-12) | ducation | (Give | dent's Usual Occup kind of work done DO NOT use retired Mechanic | during most of w | orking | 16b. Kind of Busine Washing Applianc | ss/Industry Machine |
| Maryland | | To Be C | 17. Father's Name (First, Middle, Last, Adam Kern | | | | Mar | y Engle | Maiden Sumame) | |
| e, mar | 1 and 2 steads and 2 steads and 27 last than trau | | 19a. Informant's Name/Relationship (Patricia Reaver — 20a. Method of Disposition | daughter | 1818 | Benedict | Rd., We | stminster | r, City or Town, State , Md. 211 20c. Location - City | 57 |
| Baltimore, | Page ment o ant: If ury or | | 1 | New | Luthe | sition (Name of natory or other place ran Cem. 1. Name and Addre | Nov. 28 | , 2005 | Manchest | |
| ň | permit Depart Import any inj | | 23a. Part 1. Enter the disease, or com | plications that caused the deat | 32 | 96 Charmi | ll Dr. M | hapel P.A anchester ac or respiratory arr | Md. 211 | Approximate |
| Jan G | Physician /Medical Examiner | | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a. Seesis Due to (or as a conseq | uence of): | | | | | Interval Between Onset and Death 12 days |
| b8/bU, | ate be executed hysician and the burial-transit | icai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence | | | | | | |
| O. Box 6 | sath certific attending p for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown | I death 3 | Ectopic pregnancy Other (specify) | , | | 23d. Date of o | lelivery Day Year |
| cords, P | w requires that the de been signed by the should be detached | by | Part II. Other significant conditions of | contributing to death but not resi | | nderlying cause giv | en in Part I. | | | to the cause of death? Probably 4 Munknown |
| Ľ | The la ate hes page 2 | Completed | | | | | | 24a. Was a autops perform | y prior t | autopsy lindings available o completion of cause of es 2 |
| sion of Vital | nding Physiclan: ath. r: After this certific e funeral director. | ation: To Be | 25. Was case referred to medical examiner? 1 Yes No 27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | ER/Outpatien 28b. Time of Injury | 28c. Injun Work | er: 4 🗆 Nursing | | ence 6 Other (Sport of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o | pecify) |
| DIVIS | To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Alter ti completely filled in by the funera | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | building, etc. (Specify | y) | | | City or Towr | n, State) | Rural Route Number, |
| | the Hospi nin 24 hou the Funer npletely fill | Medicai | | vsician: To the best of my kno niner: On the basis of examina and manner stated. | wled e death tion and/or inv | | | e and dua to the or surred at the time, da | ate and place, and d | ue to the cause(s) |
|) | 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 Jill 5 | / | 29b. Signature and title of certifier | 2C_mi | | 29c. Licensi | | | 9d. Date signed (Mo | |
| (| 2 | | Andrew A. Nelso | 1 10 | | RES print) pospital of | Both. | nore | | |
| 1 | Sta Registr | te ar | 31. Date filed (Month, Day, Year) NOV 2 9 2005 | 32. Registrar's Signa | ture | | | | | |

| | | | 1 - For State Registrar | State of M | aryland / Depa | artment of Hertificate of E | ealth and N Death | | gieze | 5 38222 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------|-------------------------------------------|------------------------------------------|---------------------------------------|---------------------------------------------------------------|
| | Physici /Medi | | 1. Decedent's Name (First, Middle, L | * Kalun | nucle | | | 2. Date of De Month Novem | bu 32 | Year 3. Time of Death |
| | Examir | ner | 4a. Facility Name (If not institution, go | ly Gener | al Hospidul | 4b. City, Town, or | 01m | bia | | of Death |
| L | Funeral Director | | 5. Social Security Number 6. 285-12-0111 Usual Residence of Decedent | Sex 7. Ag | e (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da December | iy, Year) | Birthplace (State or Foreign Country) Ohio |
| | yland how | | 10a. State 10b. County | | 10c. City, Town or Lo | ecation | - | | | 10d. Inside City Limits |
| | e Ma | ctor | Maryland H | loward | | Co | olumbia | | | 1 ☐ Yes 2 🗷 No |
| | h with th | al Director | 10e. Street and Number 6336 Cedar Lane Apr | t. #387 | | 10f. Zip Code | 21044 | | 10g. Citizen of V | Vhat Country? U.S.A. |
| | deatl | ner | 11. Marital Status | 12. Was Decedent Armed Forces? | | Was Decedent of His | panic Origin? (Sp | ecify Yes or No | | e - American Indian, |
| 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ire Modical Evarulisar must be notified at | by Funeral | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 Vill Yes, Give Year or Dates: | No | If Yes, specify Cuban | Specify: | Hican, etc.) | Specify | k, White, etc. : White |
| 5-0 | 72 h | etec | 15. Decedent's (Specify only highest g | | (Give | dent's Usual Occupat | iring most of work | ina | 16b. Kind of Bu | |
| 121 | within ane. than ' | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | lite. | DO NOT use retired) | nemaker | 9 | | Own Home |
| | filled Hygie ther | မ င် | 17. Father's Name (First, Middle, Las | st) | | | 18. Mother's Name | e (First. Middle | Maiden Sumam | A) |
| Maryland | 2 should be filled withir and Mental Hygiene. is marked other than aumatic event, Ite M. | To B | Georg | je O'Masta | | | | | nna Javorsk | • |
| ary | 2 should and Men is marke aumatic | _ | 19a. Informant's Name/Relationship | | 19b. Mailir | ng Address (Street ar | nd Number or Run | al Route Numbe | er, City or Town, | State, Zip Code) |
| | 1 and 2 Health tem 27 i | | Mr. Kenneth Kalumu | ick Son | | 493 Sylvan De | ell Columbia | , Maryland | 21045 | |
| 3altimore, | Pa ant ant | | 20a. Mythod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 | | | sition (Name of natory or other place) S Catholic Cen | 11/ | Date /28/2005 | | City or Town, State |
| Balt | permit. Pag Department Important: I any injury o | | 21. Sills sur- of Furn ral Secretal Vice | ensee Rich | A and a | . Name and Address Slack F | | | tt City MD 2 | 21043 |
| | | | 23a. Part1. Enter the disease, or con shock, or heart failure. List on | iplications that cause one cause on each li | the death. Do not ent | er the mode of dying | such as cardiac | or respiratory a | rrest, | Approximate Interval Between |
| | Pnysician | i E m | Immediate Cause (Final disease or condition | | Acute | respor | ctoy + | merce | , | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as | a consequence of): | | | | | |
| | Cxammer | | Sequentially list conditions, | b | - 4 | remon | | | | |
| - | led nsit | niner | cause. Enter Underlying Cause (Disease or injury | Due to (or as | a euroqueneo oth. Armill r | molen | dial. | Harri | tion | |
| | icate be executed physician and s the burial-transit | Examin | that initiated events resulting in death) Last | c | a consequence of): | yoear entestr | . / 1 1 | 0 | | |
| 8760, | e be (/sicia) | dicai | | d | Gastro. | entesti | no lile | edry | | |
| 9 | rtificat ng phy as th | Aedi | 15.55.41.5 | | , | | | | | |
| .O. Box | The law requires that the death certifit the has been signed by the attending page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date Mon | e of delivery th Day Year |
| <u>α</u> | es that igned b | by Pl | Part II. Other significant conditions | contributing to death b | ut not resulting in the u | nderlying cause giver | in Part I. | 23e. Did to | obacco use contri | bute to the cause of death? |
| rds | w require been sig should b | | | | | | | 101 | res 200 No | 3 ☐ Probably 4 ☐ Unknown |
| of Vital Records, | : The law requirate has been page 2 should | Completed | | | | | | 24a. Was | sv pr | fere autopsy findings available nor to completion of cause of |
| a | | | 2.11 | T | | | | | | eath? □Yes 2□No |
| ΖΞ | | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 Anpatie | | Other | 26. Place of Death | | | - |
| of | ding Phys h. After this funeral di | \vdash | 27. Manner of Death | 28a. Date of Inju (Month, Day | | 28c. Injury a | at at | | lence 6 Othe | |
| ion | nding ath. r: Afte e fun | atlo | 1 Anatural 5 ☐ Pending 2 ☐ Accident investigation | | y Year) Injury | Work? M 1 ☐ Ye | es 2 🗆 No | | | |
| Division | of or Atte | Certification: | 3 Suicide 6 Could not determined | | ury - At home, farm, stroc. (Specify) | eet, factory, office | | 28f. Location (S City or Tow | Street and Numbe m, State) | r or Rural Route Number, |
| | To the Hospitel or Attending PI within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral | Medical C | 29a. Certifier (Check only one) Certifying P | hysician: To the best ominer: On the basis of and manner sta | examination and/or inv | occurred at the time restigation, in my opin | , date and place, a nion, death occurr | and due to the ded at the time, d | cause(s) and man date and place, a | nner as stated. nd due to the cause(s) |
|) | within To th | M | 29b. Signature and title of certifier | - Mz | | 29c. License | | 1 | 29d. Date signed | (Month, Day, Year) Sen 22 nd 2005 |
| İ | 1/2 | | 30. Name and address of person who | completed cause of d | eath (Item 23a) (Type, | | Lane | Clar | buille | MD 21029 |
| | Sta | | 31. Date filed (Month, Day, Year) | 500 | ar's Signature | | | | | , , , , , , , , , , , , , , , , , , , , |
| N. | Registr | ar | NOV 2 9 2 | U05 30 | with the | | | | | |

| | | | For State Registrar | State of M | aryland / | Cei | artment of F rtificate of | dealth an Death | a Mental H | ygien Reg. N | | 38223 |
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| Phy | /sicia | | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of D | | ay Yeer | 3. Time of Death |
| 70396- | /Sicia ledic | al | Gladys W. Kon | | | | , | | NOV | | 6 2005 | 7:17 PM |
| Exa | amin | er | 4a. Facility Name (If not institution, giv | | | | 4b. City, Town, o | | | 40 | c. County of Deeth | |
| | | | SAINT AGNES 5. Social Security Number 6. S | (105P (TA | e (In yrs. last | hirthdayl | If Under 1 Year | If Under 24 | | lieth | n/a | alana (Stata or Forming |
| Fune Direc | | | | □ M 2/ÅF | 85 | Yrs. | Months Days | | Hrs. 8. Date of 8 (Month, L. 12/9 | 719 | Coul | place (State or Foreign htry) EXAS |
| land | 4 | | 10a. State 10b. County | | 10c. City, To | wn or Lo | cation | | | | 1 | 0d. Inside City Limits |
| Mary I-fah | 50 | to | Md n/a | | | Balt | imore | | | | | 1 X Yes 2 No |
| h the | Sugar | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. C | itizen of What Cou | ntry? |
| death with the Maryland ms 23a or 28a-f ahow | 181 | alD | 602 S. Kenwood | Ave. | | | 212 | 24 | | 1 | USA | |
| ir dea | | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | | 13. | Was Decedent of H | Hispanic Origin? an, Mexican, Pi | (Specify Yes or Nuerto Rican, etc.) | lo- | 14. Race - Americ Black, White, | |
| ING 21215-UU36 be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or Items 23a or 28a-f ahow | EXAM | þ | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 []A If Yes, Give Year or Dates: | No | 1 | I□Yes 2MNo | | | | Specify: | ite |
| 72 h | | Completed | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16 | (Give | lent's Usual Occup kind of work done | during most of | working | 16b. | (ind of Business/In | dustry |
| within 72 ene. | | du | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | _ | DO NOT use retire | d) | | | | |
| be fited v tal Hygie | E. | | 17. Father's Name (First, Middle, Last) | | | 260 | cretary | 18 Mother's | Name (First, Middle | | odyear [| lire |
| | | o Be | Joel Wallace | | | | | | y Cause | | · Cumano, | |
| aryla 2 should and Men ie marke | | ၉ | 19a. Informant's Name/Relationship (| Type, Print) | 11 | 9b. Mailir | g Address (Street | | - | | or Town, State, Zip | Code) |
| _ c = rq : | other treumatic | | Mr. George Kon | ig / Son | | | | | | | | 1. 21228 |
| Ges 1 a | | | 20a. Method of Disposition | - | | | sition (Name of natory or other place | | Date | | ocation - City or To | |
| Pages nent of unt: If it | lo Arr | | 1 ABurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify | | 1 | | | | /30/05 | Ba1 | timore, | Md. |
| Baltimore, permit. Pages 1 a Department of Hea | eny injury | | 21. Signature of Euneral Service Lice | S00 D | 1 | | | | uneral 1 | | | |
| 10 gg E 3 | ă | _ | Cuge | Car | TIM | | | | | | nore, Mo | 1. 21224 |
| | 546 | | 23a. Part1. Enter the disease, or const shock, or heart failure. List only | plications that caused one cause on each li | the death. D | o not ente | er the mode of dyin | ng, such as card | diac or respiratory | arrest, | | Approximate Interval Between |
| Physic | | | Immediate Cause (Final disease or condition | a BA | CTEPU | AL | PNEU | monsk | -) | | | Onset and Death |
| /Medi Exami | | | resulting in death) | | a consequenc | , | 61 | | | | | |
| , 35° g | 3 | <u></u> | Sequentially list conditions, | 0. | a consequence | | SHOUL | | | | | |
| pe : | isi. | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 000 10 (01 23 | a consequenc | 0 01). | | | | | | |
| y axecu and and | al-tra | xar | that initiated events resulting in death) Last | c. Due to (or as | a consequenc | e of): | | | | _ | - | |
| 68/6U filicate be e | ina e | | | d | | | | | | | | |
| 68 / 60, tificate be executed ig physician and | Ses | ledical | | | | | | | | | | 245 32 |
| BOX 68/6U, eath certificate be executed attending physician and | es n | Z | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome 1 □ Live birth | | th 3 | Ectopic pregnancy | | | | 23d. Date of delive | ry |
| deat deat | O Da | sicis | in the past 12 months? 1 Test 2 No | 4 ☐ Pregnant at | | | Other (specify) | | | | Month | Day Year |
| The law requires that the death cer | agaci | by Physician/N | 9 🗆 Unknown | | | | | | | | | |
| S, les th | | | Part II. Other significant conditions of | | ut not resulting | in the ur | iderlying cause giv | en in Part I. | | | use contribute to th | |
| Ord requir | 200 | ted | CV STROK | | | | - | | _ 10 | Yes 2 | No 3 Prob | ably 4 DUnknown |
| Hecords, he law requires to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a has been signer to a | M. | Completed | THROAT | CANCE | n | | | | 24a. Was | psy | prior to cor | osy findings available inpletion of cause of |
| | g D | ဝီ | ATTLEAC | FIBRILL | ATVOR | 7 | | | perf 1 ☐ Yes | ormed? | death? | |
| Of VITal Physicien: T | actor | Be | 25. Was case referred to medical examiner? | Hospital: | | | Oth | | Death (Check only | | | |
| ال الله الله الله الله الله الله الله ا | 2 | 2 | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injur | ont 2 ER/C | Outpatien | 3 DOA | 4 Nursing | | | 6 Other (Specify |) |
| c g ag | 2 | Certification; | Natural 5 Pending investigation | (Month, Day | y Year) | Injury | 28c. Injun Worl | yai k? Yes 2 □ No | 28d. Describe | now inju | ry occurred | |
| DIVISION I or Attending after death. Director: After | a li | fica | 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of Inju | ury - At home, | farm, stre | | | 28f. Location | (Street ar | nd Number or Rura | l Route Number |
| spitel or / | | ert | 4 Homicide determined | building, etc | c. (Specify) | | ,,, | | City or To | | | |
| UIVISIO • Hospitel or Attendi • A hours after death. | E | Medical C | 29a. Certifier 1 Certifying Ph (Check only one) | ysician: To the best of niner: On the basis of and manner sta | r examination a | ge, death and/or inv | occurred at the tin estigation, in my o | ne, date and pla pinion, death o | ace, and due to the courred at the time, | cause(s , date and |) and manner as st d place, and due to | ated. the cause(s) |
| To the Hosp within 24 ho To the Fund | duo | Me | 29b. Signature and title of certifier | | | | 29c. License | e number | | 29d. Da | te signed (Month, I | Day, Year) |
| / / | | | 1 Bush | | | | P | 1951 | 5 | NT | 26,2 | 200 |
| 1 | | | | completed cause of d | eath (Item 23a |) (Type, I | Print) | | | | | |
|) | | | DRICEYURIUMA | R BUCH | 900 | CA | TON AVE | E, BAL | TIME | · m | 0 212 | 29 |
| | Stat | 100 | 31. Date filed (Month, Day, Year) | completed cause of d R B U H 32. Registra 2005 | ar's Signature | | Sack 3 | | | | | |
| 40 0 | gistra | | NOV 2 8 | 2005 | gas a de | P. A | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | | | |
| DHMH 17 Re | v 1/20 | 01 | , | at the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the | | , | | | | | | |

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| | | | 1- State of Maryland / I | Department of Health and M Certificate of Death | dental Hygier | |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death | 3. Time of Death |
| | Physici /Medio | | Helen Frances Lance | | | 25. 2005 4:00 A M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death |
| | | | 715 Maiden Choice Lane, CC617 | Catonsville | | Baltimore |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last bit | Months Days Hours Min. | 8. Date of Birth (Month, Day, Yee | 9. Birthplace (State or Foreign Country) |
| | Director | | 219-01-2229 86 | Yrs. | OCT 1, 19 | |
| | and and | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow | m or Location | | 10d. Inside City Limits |
| | Marylan f show | 0 | Maryland Baltimore | 0 | | 1 □Yes 21√2 No |
| | 28a | Director | 10e. Street and Number | Catonsville | 10a. (| Citizen of What Country? |
| | 3a oi | | 715 Maiden Choice Lane, CC617 | 21228 | | |
| | death ms 2 | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. Was Decedent of Hispanic Origin? (Spe | ecify Yes or No- | USA 14. Race - American Indian, |
| 9 | after or Ita | Ē | 1 Never Married 2 Married 1 Yes 2 No | If Yes, specify Cuban, Mexican, Puerto | Rican, etc.) | Black, White, etc. |
| 93 | ral', | 1 by | 3 Widowed 4 □ Divorced If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | | Specify: White |
| 21215-0036 | be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show avant, Ira McJical Erar; it ar mast be notified at | Completed | 15. Decedent's Education 16a (Specify only highest grade completed) | . Decedent's Usual Occupation (Give kind of work done during most of work) | ing 16b. | Kind of Business/Industry |
| 121 | within ene. than ' | mpi | Elementary/Secondary (0-12) College (1-4or 5+) | life. DO NOT use retired) | | State of Maryland |
| 2 | filed v Hygie sthar t | | 17. Father's Name (First, Middle, Last) | Secretary | | · · · · · · · · · · · · · · · · · · · |
| Maryland | a tal | Be | Marty Allan Locaty | | e (First, Middle, Maide | |
| 2 | d 2 should be the and Mental I Is marked of Traumatic ava | ဥ | | D. Mailing Address (Street and Number or Rura | en A. Ca | |
| Ma | d 2 s th ar 7 ls trau | ńij | | | | |
| | s 1 and 2 if Health itam 27 l | 1 | Robert A. Lance, Jr./Son 6 20a. Method of Disposition 20b. Place o | 157 Committment Confidence of Disposition (Name of party, crematory or other place) | Ourt Col | UMD13, MU Z1045 Location - City or Town, State |
| ομ | Pages nent of int: If it iry or o | | T Dougl S Community 3 Chambra nom State | i i |) E /OE | D-11' 100 |
| Baltimore, | artme ortan injur | l i | 21 Signatural Standard Licenses | Crematory, Inc. 11/2 22. Name and Address of Facility | | Baltimore, MD |
| Ba | permit. Pages 1 and Department of Heall Important: If itam 2 any injury or othar once. | | Edward A, Gregorchik | C: | | Society of MD, Inc. |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do | 299 Frederick Road not enter the mode of dying, such as cardiac of | | Approximate |
| | Pnysician | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | | Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) a Due to (or as a consequence | | | Years |
| | Examiner | | Sequentially list conditions b. | | | |
| | p == | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | of): | | - |
| (| and trans | Examiner | that initiated events | | | |
| 00 | be executed sician and burial-transit | Ë | resulting in death) Last Due to (or as a consequence | of): | | |
| 8760, | ate hys the | dicai | d | | | |
| 9 xo | n certific Inding p use as | /Me | IF FEMALE: 23c. If yes, outcome of pregnancy | | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | |
| Bo | eath certifi attending for use as | ian | in the past 12 months? | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of delivery Month Day Year |
| o. | at the de by the tached | Physician/Me | 1 Yes 2 No 9 Unknown 9 Unknown | 3 Other (specify) | | |
| ٩ | the ed | | Part II. Other significant conditions contributing to death but not resulting in | n the underlying cause given in Part I. | 23e. Did tobacco | use contribute to the cause of death? |
| Vital Records, | The law requires tte has been sign bage 2 should be | d by | | | 1 ☐ Yes | 2 □ No 3 □ Probably 4 ☐ Unknown |
| S | tw requir s been s should | Completed | | | 24a. Was an | 24b. Were autopsy findings available |
| Re | The la ate has page 2 | mo | | | autopsy performed? | prior to completion of cause of death? |
| tal | (0 - | Φ | 25. Was case referred to medical | 26. Place of Death | 1 Yes 2 | lo 1 Yes 2 No |
| | ysic s ce direc | 0 | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou | Other | | 6 ☐Other (Specify) |
| υot | | T :uc | | Time of 28c. Injury at 28c. Injury Work? | 28d. Describe how inj | |
| Ö | Attandia death. ctor: Al y the fu | atic | 2 Accident investigation | M 1 ☐ Yes 2 ☐ No | | |
| Division | il or Attand after death Diractor: / | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, fa building, etc. (Specify) | irm, street, factory, office | 28f. Location (Street a City or Town, Sta | and Number or Rural Route Number, te) |
| | Hospital or Attanding 14 hours after death. Funaral Diractor: Afte tely filled in by the fune | | | | | |
| | To tha Hospital within 24 hours a To tha Funaral I completely filled | edicai | 29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) | death occurred at the time, date and place, a id/or investigation, in my opinion, death occurre | and due to the cause(ed at the time, date a | s) and manner as stated. nd place, and due to the cause(s) |
| | To tha within 2 To tha complet | Mec | 20h Signatura and title of partition | 29c. License number | 29d. D | ate signed (Month, Day, Year) |
| | ⊢ ≯ ⊢ ŏ | | had be | n 25000 | | |
| • | \0 | 1 | 30. Name and address of person who completed cause of death (Item 23a) | (Type Print) | NO | vember c5 2005 |
| | ٢ | | Mula M Casacottes MD 711 | Maiden Chaire | La Cat | and allicen |
| | Sta | te | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | D 30989 (Type, Print) Maiden Choice | - 1 | MONING 1710 |
| | Registr | ar | NOV 2 9 2005 Street 15 | Goarde | | |

| | | | For State Registrar | | State | of Man | | partment of I Prtificate of | | nd Mental H | -/11 | 05 | 38225 |
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| Phy | siciar | | 1. Decedent's Name | (First, Middle, L. | ast) | | | | Douin | 2. Date of I | | | 3. Time of Death |
| /M | edica | 1 | JEROME | | | | | | | Month | - 2005 | Year | 1:30 AM |
| Exa | mine | r | 4a. Facility Name (II FUTURE (| _ | | _{imber)} W00Î | | 4b. City, Town, o | | Death | | ty of Death | |
| Fune | ral | | 5. Social Security N | | IERKY Sex | | n yrs. last birthda | REISTERS | If Under 24 | Hrs. 8 Date of F | BALT | MORE | |
| Direc | | | 217.26.58 | 15_ | 1⊠ M 2□ F | 76 | Yrs. | Months Days | Hours | Hrs. 8. Date of E (Month, I 05 · 20 | Day, Year) 1929 | Cou | place (State or Foreign intry) |
| land | | | Usual Residence of 10a. State | Decedent 10b. County | | 10 | Dc. City, Town or | Location | | TO PO | | | |
| the Marylar 28a-f show | Ì | 5 | MD | NIA | 1 | | BALTIMOR | | | | | | 10d. Inside City Limits 1 Yes 2 No |
| ith the | lroc | 2 | 10e. Street and Nun | | | | 21711010 | 10f. Zip Code | | | 10g. Citizen o | f What Cou | |
| death with the Maryland ms 23e or 28a-f show | 107 | | | HNAL F | POAD | | | 21229 | | | l | ISA | |
| re, Maryland 21215-0036 s 1 and 2 should ba filed within 72 hours after death with the Maryla f Health and Mental Hygiene. titien 221 is marked other then "natural", or Items 23e or 28e±1 show other thermatic event. If the Maryla contract the markler in the markler in the markler of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of t | Funeral Director | | Marital Status Never Marrie | nd 200 Married | 12. Was Dec | orces? | r in U.S. | . Was Decedent of H If Yes, specify Cub | lispanic Origin' an, Mexican, P | ? (Specify Yes or Nuerto Rican, etc.) | lo- 14. Ri | ace - Ameri | can Indian, etc. |
| d 21215-0036 filed within 72 hours after Hygiene. inther then "netural", or Ite and the file with the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the filed beautiful the file | À | 2 | 3 Widowed | - | 1 ☐ Yes If Yes, Gi Year or D | ve ` | | 1 ☐ Yes 2 🔼 No | Specify: | | Spec | | |
| 5-0 72 hc | Completed | | (Speci | 15. Decedent's E fy only highest gr | ducation ade completed) | | 16a. Dec | edent's Usual Occup le kind of work done DO NOT use retired | pation | | 16b. Kind of | | |
| 2121 2121 od within giene. | 100 | | Elementary/Secon | dary (0-12) | College (| 1-4or 5+) | - | _ | | working | 2=6 | | |
| d 212 d 212 i filed with t Hygiene other the | Re C. | 5 | 12 TH GR 17. Father's Name (| | , NA | | PUKN | MURE FIN | | Name (First, Middle | REIAI | | |
| Maryland 212. 6 2 should ba filed within the and Mental Hygiene. 7.7 Is marked other then treumetic event, the Menter treumetic event, the Menter treumetic event. | L C | | LARSON L | EE | | | | | BEULA | | | unej | |
| Aary Land Is me | | | 19a. Informant's Na | _ | / | | 19b. Mai | ling Address (Street | | | | n, State, Zip | Code) |
| re, N is 1 and of Health item 27 other tr | | _ | DEBORAH 20a. Method of Dispo | LEE | (WIFE) | | | BEIHNAL | RD., | BALTIMOR | | 2122 | 29 |
| | | • | | Cremation 3 | Removal from | State | cemetery, cri | osition (Name of ematory or other place | | Date | 20c. Location | - | |
| artin artin inju | ej l | ř | 21. Sinature of Fun | | | 1 | MT. ZION | | II. | 30 · 05 | BALTIM | IORE, | MD |
| Be gen | ouce | | Mhu | Wille | > | | V. | 2. Name and Addre JUGHN C. GI 151 ВАИО. N | REENE FL | NERAL SER | 2VICE 21229 | | |
| Prysicia /Medic Examina | al er | | Immediate Cause (F disease or condition resulting in death) | inal | a Due to | or as a co | 1 .) | eter the mode of dyin | g, such as card | liac or respiratory a | arrest, | | Approximate Interval Between Onset and Death |
| 68760, filtrate be executed physician and is the burial-transit | edical Examiner | i | Sequentially list configure, leading to immunicate of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequ | | c | | nsequence of): | | | | | | |
| Box edeath certified attending | Physician/Med | 1 2 | F FEMALE: 23b. Was decedent printhe past 12 mr 1 Yes 2 9 Unknown | nonths? No | 4□Pregn 9□Unkno | irth 2 🗌 ant at time own | Fetal death 31 of death 51 | □Ectopic pregnancy □ Other (s <i>pecify</i>) | | | | ate of deliver | ry Day Year |
| ds, P.C uires that the signed by to d be detach | by | | art II. Other signific | ant conditions o | ontributing to de | ath but no | t resulting in the t | inderlying cause give | n in Part I. | | | | e cause of death? |
| () > 0 5 | letec | r | | | | | | | | · · | | 3 Proba | ably 4 Unknown |
| - I te | Completed | - | | | | | | | | | osy ormed? | Were autop prior to com death? 1 \(\text{Yes}\) 2 | sy findings available apletion of cause of |
| | To Be | 2 | Was case referre examiner? 1 ☐ Yes 2 ☑ No. | | Hospital: | mations | 2 ER/Outpatie | Othe | | eath (Check only c | | | |
| On O ding Pt n. After th | Certification: T | 2 | 7. Manner of Death 1 Natural 2 Accident 3 Suicide | 5 Pending investigation 6 Could not be | 28a. Date o (Monti | | | 28c. Injury Work | 4 Nursing | Home 5 Resid | dence 6 Doth | | |
| Divi | | | 4 Homicide | determined | 28e. Place | of Injury - / g, etc. (Sp | At home, farm, str necify) | eet, factory, office | | 28f. Location (S City or Tox | Street and Numb vn, State) | er or Rural | Route Number, |
| Division To the Hospital or Attention 24 hours after deatl To the Funerel Director: completely filled in by tha | Medical | | one) | 1 | rsician: To the iner: On the ba and mann | SIS UI GRAII | knowledge, deat nination and/or in | n occurred at the time vestigation, in my opi | e, date and placinion, death occ | ce, and due to the courred at the time, | cause(s) and ma date and place, a | inner as sta and due to t | ted. the cause(s) |
| To To CONT | 2 | 2 | 9b. Signature and tit | le of certifier | - m! |) | | 29c. License | | | 29d. Date signed | d (Month, D | ay, Year) |
| | 1 | - | Name A. | | 1 | | | 17 | 2756 | .9 | 111 | 28/0 |) |
| 7 | | | Name and address Date filed (Month, | en b | etiles | Win | 18 | Print) 38 G | Rene | Tree | Rel | L | 1205 |
| Regis | tate trar | ľ | | V 2 9 28 | 9 5 | gis rar's Si | gnature | Char | | | | truppe - te- | |

| | | | 1 - For State Registrar | State of Ma | aryland / D | epartme Certifica | ent of He | ealth and N Death | | giene 005 | 38226 |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------|--------------------------------------|--------------------------------------------------|---------------------------------------|----------------------------------------------------------|----------------------------------------------------|
| | Physic /Medi | | Decedent's Name (First, Middle, Las Roger | <u></u> | | Lo | ckett | Jr. | 2. Date of De. | | |
| | Examir | | 4a. Facility Name (If not institution, give | HOSP 1 | TAL | | BACT | ocation of Death | | 4c. County of De | - |
| | - Funeral Director | | | X 7. Age | 66 Y | rs. Month | | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Date 09 | y, <i>Year)</i> 39 9. Bi | rthplace (State or Foreign Country) MD |
| | ith the Marylan or 28e-f ehow | Director | 10a. State 10b. County MD NA | | 10c. City, Town Balti | | | | | | 10d. Inside City Limits 1 Yes 2 No |
| | eath with the 23a or 21 | | 10e. Street and Number 3006 Presstman | | | | Zip Code 212 | | | 10g. Citizen of What C | • |
| 036 | n 72 hours after death w "naturel", or Iteme 23a edicel Examinar musi I | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates: | | | 37 | panic Origin? (Sp Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | |
| Baltimore, Maryland 21215-0036 | is and 2 should be filed within 72 hours after death with the Maryland Fleatih and Mental Hygiene. Fleatih and Mental Hygiene. It was 23 or 28e-1 ehow tem 27 is marked other than "natural", or Items 23a or 28e-1 ehow other traumatic event, the Medical Examinational Carolified at | Completed | 15. Decedent's Edu (Specify only highest grad | le completed) College (1-4or 5- | +) | Decedent's Us Give kind of the DO NOT Labor | | on ring most of work | ing | 16b. Kind of Business | • |
| land 2 | 2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma | To Be Co | 6th grade 17. Father's Name (First, Middle, Last) Roger Lockett S | na r. | | Labor | 11 | | | M.G. Ind Maiden Sumame) ackston | ustry |
| , Mary | ss 1 and 2 should lof Health and Menitare 27 is marker other traumatic | - | 19a. Informant's Name/Relationship (T) Betty Lockett-W | rpe, Print) | | | ss (Street and | d Number or Rura | I Route Numbe | r, City or Town, State, | Zip Code) Md 21216 |
| imore | Page: nent or sent: If ury or | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | lemoval from State | 20b. Place of E cemetery, | | | l I | | 20c. Location - City of Baltimo | |
| Ball | permit. Pag Department Importent: t any injury o | | 21. Signatur of Funeral Service Liceas | · Jun | tt | Marc 4300 | nd ffd/fi Waba | ਿੱਲੀਉਂSt sh Ave, | Balti | imore, Md | |
| | Priysician /Medical | | 23a. Pan1. Enter the disease, or complet spock, or heart failure. List only or mediate Cause (Final is se or condition thing in death) | LUNCAR | - 16 | LACT | | Such as cardiac of | | rest, | Approximate Interval Between Onset and Death |
| TT, ROGER 8760, < | Examiner physicien and the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | consequence of) | n_ w | IH N | A ET AST | MSis T | O LIVER | |
| O. Box 68 | The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as to | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti | Fetal death | 3 Ectopic | pregnancy Specify) | | | 23d. Date of del Month | ivery Day Year |
| A | v requires that the de been signed by the should be detached | ed by Ph | Part II. Other significant conditions con | tributing to death but | not resulting in th | ne underlying | cause given i | n Part I. | | pacco use contribute to | the cause of death? |
| al Reco | ician: The law re certificate has be ector, page 2 sho | | | | | | | | 24a. Was an autops perform | y prior to o | atopsy findings available completion of cause of |
| Division of Vital Records | d dia | ation; To Be | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | ospital: 1 Inpatient 28a. Date of Injury (Month, Day) | | | OA Other: 28c. Injury at Work? | 5. Place of Death 4 Nursing Hon 2 5. 2 No | ne 5 ☐ Reside | e) Ince 6 □Other (<i>Spe</i> e Iw injury occurred | cify) |
| Divis | | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. | | | | | City or Town | • | |
| | o the Hosi ithin 24 ho o the Fune ompletely f | Medical | 29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin 29b. Signature and title of certifier | ician: To the best of er: On the basis of e and manner state | xamination and/o | rinvestigation | d at the time, on, in my opinion | on, death occurre | d at the time, da | ate and place, and due | to the cause(s) |
| | (h | | 30. Name and address of person who con | inpleted cause of dea | th (Item 23a) (Tv | - | C 60 | 2500 |) | Pd. Date signed (Month | 2005 |
| 100 | Stat | e | ETTENNE NGO 31. Date filed (Month, Day, Year) | Jaz. Registrar's | 0109 C | TON | AVER | rue, B | AUTIM | LORE, MD | 21229 |
| | Registra | ir 🤻 | NOV 2 9 2005 | Bolow 1 | T ALCO | acad . | | | | | |

State of Maryland / Department of Health and Mental Hygierje 0.538227 Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 28, 2005 November Ann H. Lugowski 4:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 715 Maiden Choice Ln., Apt. CC120 Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y May 15, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 86 213-18-6066 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other treumetic event, the Medical Examinar must be notified at Baltimore 1 ☐ Yes 2 No Maryland | Catonsville Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 715 Maiden Choice Ln. Apt. CC120 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personnel Director State of Maryland if Health and Mentai Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be fi Be Mary E. Hibbitts Martin A. Huber ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other treun 1217 Canberwell Road, Catonsville, MD 21228 Genevieve Poplawski, Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 2, 2005 * 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave., Catonsville, MD 21228 M01290 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart cliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rena **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impry that initiated events Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Box 68760, ∠ resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No P.O. detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ this 28a. Date of Injury (Month, Day Year) 28b. Time of completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. M 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04437 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muiden Choice Lane, Catonsville, MD 21228 Deneen Bowlin
31. Date filed (Month, Day, Year) Bowlin 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Year **Physician** Ethel 2 30 AM Levin 11 23 JUN 6 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Jewish Convalescent & Nursing Home | Dalling | Dalling | House 24 Hrs. | 8. Date of Birth (Month, Dey, May 27, Baltimore Baltimore 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1□ M 20 F 097-18-5343 82 Director 1923 Usuel Residence of Decedent filed within 72 hours efter deeth with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Modical Examiner must be notified at 1 ☐ Yes 21 No Funeral Director Maryland | Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4115 Century Towne Road 21133 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed withir Department of Health end Mental Hygiene. Important: If Item 27 is merked other than Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Wholesale Drugs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Herman Rebecca (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Donna L. Levin, Daughter 4115 Century Towne Rd., Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Montefiore Cemetery 30, 2005 Farmingdale, New York 5 Other (Specify) 4 Donation 21. Signatur of Fur eral Service Licensee 22 Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. M01290 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Concer Examiner Physician/Medical Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be deteched for use es the buriel-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XUnknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 2 DN0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Yes 2 12 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number ELJUA MOTUT 10 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Brahim Elouardighi, MD. 2434 Belvedere Ave., Baltimore, MD 21215 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

RENEE D. LIGON 05-07743 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27, perME,GS1,1/1/06 The Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 16, 2005 **Physician** Ligon Renee 17:45pm[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1703 DRUID HILL AVE BALTIMORE If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country)
 MS 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 12 05 **Funeral** Year) 1 ☐ M 2 💢 F Director 299-56-1003 47 Yrs 57 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inspartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21217 1703 Druid Hill Ave by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes YNO If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3€Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 4yr+ Elementary/Secondary (0-12) Howard Comm. College Teacher 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eudine Myles Leon Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Central Ave #607, Dayton, Ohio 45406 Eudine Wilson-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Unit Donation 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) West Memory Garden 12/01/2005 Dayton, Ohio 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

124b. Yes 2 \(\subseteq \) No 24a. Was an autopsy performed? Division of Vital 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Hospital: 1 XYes 2 □ No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of . Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 [XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Denis O.C.M.E. NOVEMBER 17,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABIUCCITH 111 PENN STREET BALTIMORE MARYLAND 21201 32. Restrar's Signature 31. Date filed (Month, Day, Year) State NOV 29 2005 Registrar

| | | 1 | For State Registrar | State of Mary | | partmen <i>ertificat</i> | | | | Reg. No | 000 | 38230 | |
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| | mine | r 4 | 5. Social Security Number 6. | PITAL OF B | Yrs. last birthda | ay) If Under | BALT | If Under 24 I | CITY | Birth Day, Year) | 9. Bi | ath irthplace (State or Forei | gn |
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| with the | | Dire | 10e. Street and Number | | | 10f. Zip | | 1215 | | 10g. Ci | tizen of What C | Country? | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked or other than "natural", or thems 23a or 28a-1 show any infury or other train. | | Dy Fur | 3615 W. Belvedere A 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? | r in U.S. 1 | 3. Was Deced If Yes, spec | dent of Hisp cify Cuban, | | ? (Specify Yes or uerto Rican, etc.) | No- | 14. Race - Am Black, Wh Specify: | | |
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| permit. Pages Department of Important: If It | once. | | * 4 □ Donation 5 □ Other (Special Service Lice) 21. Signature of Funeral Service Lice | | - 1. | 22. Name ar | | of Facility | 21-05 A. 638 N. | | nsville, St. Bal | MD to, MD 21217 | |
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| Examir | ner | | | b. Due to (or as a co | RENAL | FAIURE | | | | | | 3 days | _\ |
| BOX COTOU, eath certificate be executed attending physician and for use as the harial-transit | o Dollar nansin | er . | Sequentially list conditions, if any, leading to immediate the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the | c. MRSA Due to (or as a co | PN unsequence of): | IONIA | | | | | | 3 days | |
| . 0 07 | מומל זמן מפת פא | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown | Fetal death | 3 ⊟Ectopic pi 5 ⊟ Other (sp | | | | - | 23d. Date of de Month | elivery Day Year | |
| law requires that the de as been signed by the | | Dy P | Part II. Other significant conditions DIABETES | contributing to death but no | _ | e underlying o | ause given | n in Part I. | | _ | | to the cause of death? Probably 4 □Unknow | /n |
| The lay | bage 2 | Completed | CHRONIC R | ENAL FAILURE | | | | | 24a. W a p 1 \(\text{Ye} | utopsy erformed? | prior to death? | autopsy findings available completion of cause of | le |
| ding Physician: Th h. After this certificate | | 0 0 | 25. Was case referred to medical examiner? 1 Yes | Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye | 2 ER/Outpat 28b. Time (ar) | | Other 28c. Injury a Work? | 4 🗆 Nursin | Death (Check on ng Home 5 R 28d. Descri | esidence | | ecify) | |
| To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the control of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of the physician of t | am ya m ba | Certification; | 2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine | be Ogo Place of Injury | | street, factory | | | 28f. Locatio City or | n (Street ar Town, State | nd Number or F 9) | Rural Route Number, | |
| e Hosph 24 hour e Funeri | iletely fill | edical | 29a. Certifier 1 Tertifying (Check only one) 2 Medical Ex | Physician: To the best of m aminer: On the basis of exa and manner stated | y knowledge, de amination and/or | eath occurred r investigation | at the time , in my opii | , date and pl nion, death o | lace, and due to occurred at the tin | the cause(s |) and manner a d place, and du | as stated. ue to the cause(s) | |
| To th To th | comp | - | 29b. Signature and title of certifier | 1 | MS | 290 | c. License | | | | te signed (Mor | | |
| ľ | 7 | | 30. Name and address of person wh | | (Item 23a) (Typ | | -0.57 | 100000 | 000 | 201 | | 2 13, 2005 | |
| ** | Stat | e | 31. Date filed (Month, Day, Year) | 32. Registrar's | Signature | | INAI | Hos | PITAL | of B | ALTIMO | 1 E | |
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| P | Physicia /Medic | | Anna Leit | ner | | | | Novemb | er 27,20 | |
| | Examin | | 4a. Facility Name (If not institution, give st | | | 4b. City, Town, or | Location of De | | 4c. County of Dea | |
| 4 | | <u>.</u> | Esther's Place 5. Social Security Number 6. Sex | 7. Age (In yrs. la | et hirthday) | Baltimo | re If Under 24 H | S. 8 Date of Birth | N/A | rthplace (State or Foreign |
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| | ahow | J. | 10a. State 10b. County | | Town or Lo | | | | | 10d. Inside City Limits 1 X Yes 2 ☐ No |
| | 28a-f | rect | Md n/a | | Balti | 10f. Zip Code | | | 10g. Citizen of What C | country? |
| | 3s or | Funeral Director | 2901 E. Strathmo | ore Ave | | | 209 | | USA | |
| | ams 2 | ner | | Was Decedent Ever in U.S Armed Forces? | 6. 13. \ | Was Decedent of Hi f Yes, specify Cuba | ispanic Origin? n. Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | 14. Race - Am Black, Wh | |
| 36 | s afte | | 1 Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 🔀 No | Specify: | | Specify: | |
| 21215-0036 | 72 hours after death with the Maryland 'natural', or Itams 23s or 28s-f ahow disal Examination to the confilled at | Completed by | 15. Decedent's Educ | ation | 16a. Deced | ient's Usual Occupa | ation | | 16b. Kind of Busines | hite s/Industry |
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| Ž | 2 should and Men is marke aumatic | 2 | 19a. Informant's Name/Relationship (Typ | | 19b. Mailir | ng Address (Street a | | • | r, City or Town, State, | Zip Code) |
| | and 2 salth all n 27 is | | Philip J. Leitn | er | 609 5 | . Lakew | A boor | e. Balt | imore, M | d. 21224 |
| Baltimore, | tar itar | | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re | moval from State | imetery, cren | sition (Name of natory or other place | | Date | 20c. Location - City o | _ |
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| Bal | permit. Page Department of Important: If any injury or once. | | 21. Signature of Funeral Service Live see | DON | | | | eral Ho | | d. 21222 |
| | oq. | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one | eations that caused the death | | er the mode of dvin | g such as card | ac or respiratory an | imore, Mo | Approximate |
| | rnysician | | shock, or heart failure. List only one Immediate Cause (Final disease or condition | ACT / A of C | lan | he a | ndio | Macul | O MI | Interval Between Onset and Death |
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| 8760, | death certificate be executed e attending physician and of for use as the burial-transit | Physician/Medical | d. | | | | | | | - |
| 9 | ertifica ding pl | Med | IF FEMALE: | Bc. If yes, outcome of pregnar | 2014 | | | | | |
| Вох | eath certific attending p for use as (| clan/ | in the past 12 months? | 1 Live birth 2 Fetal 4 Pregnant at time of de | death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of de Month | elivery Day Year |
| 0 | the che | hysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | | | | | |
| S, D | ss that gned b | by P | Part II. Other significant conditions cont | tributing to death but not resu | lting in the u | nderlying cause give | en in Part I. | | bacco use contribute | |
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| alF | | e Col | OS Was ages referred to medical | | <u> </u> | | 00 01 | 1 ☐ Yes | 2 No 1 Ye | s 2 No |
| Z. | Phyaician: this certific | 0 B | 25. Was case referred to medical examiner? 1 Yes 2 No | ospital: 1 ☐ Inpatient 2 ☐ I | ER/Outpatien | t 3 DOA Othe | | eath (Check only of | ne) lence 6 □Other (Sp. | ecify) |
| ם ר | | n; T | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of | | / at | - | ow injury occurred | |
| siol | Attanding r death. actor; After by the fune | catic | 2 Accident investigation 3 Suicide 6 Could not be | | | | Yes 2 □ No | | | |
| Division | l or Attan after deatl Diractor; I in by the | ertification; | 4 Homicide determined | 28e. Place of Injury - At ho building, etc. (Specify | me, tarm, str | eet, factory, office | | City or Tow | Rtreet and Number or F m, State) | Hurai Houte Number, |
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| | To t | Σ | 29b. Signature and title of certifier | 1/00 | Mis | 29c. License | number | 33 | 29d. Date signed (Mor | gh, Day, Year) |
| , | 4 | | 30. Name and address of person who con | modeled cause of death (line | 230) /T | Print) | 210, | 1 - | 1001 | _ * |
| 0 | , | | 261. S. 1716 | laul /w | (50 | Chmo | N 1 | 40 7 | 1227 | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signat | ure | | | | | |
| | Registi | ar | 11/20/00 | 101 9 9 2005 | East . | Re A | Carl a | | | |

DHMH 17 Rev 1/2001

Raymond Lucas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-07912 NJM State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 23 Raymond 2005 November 1840 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Easton Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 216-40-2162 Director a Usual Residence of Decedent 10b. County permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "netural", or iteme 23e or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at ane. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No by Funeral Directo Immare Daltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? WSA 12. Was Decedent Ever in U.S. Amed Forces? 1 by Yes 2 □ No If Yes, Give Year or Dates://4/2 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laymon D Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucas Dundalk, MD Z/222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) Da Itmore 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Bradley-ASLton Funeral Home Ley- HSL 401455 Dring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asthma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires thet the death certificate be executed the ettending physicien and hed for use as the burial-transli Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by atherosclerotic Hypertensive cardiovascular diseare 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1√2 Yes 2 □ No 27. Manner of Death 28a. Oate of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗓 Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) miD

0

31. Date filed (Month, Day, Year) State Registrar

LING

NOV 2 8 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



OCME

111 Penn Street

November, 24, 2005

Baltimore, Maryland 21201

| 9 | Phy /M Exa | /sician ledical aminer |
|--------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Vital Records, P.O. Box 68760, | sician: The law requiras that the death certificete be executed | cartificate has been signed by the attanding physicien and linector, paga 2 should be datached for use es the bunel-trensit |

| | | | Please Type or Print in Black Indelible Ink. State of Maryland / Department of Ho | | | jienę | |
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| | | | Certificate of L | | | leg. NZ 005 | 38233 |
| | | | 1. Decedent's Name (First, Middle, Last) | | 2. Dete of Dee Month | th Dey Year | 3. Time of Death |
| | Physicia /Medic | al le | Dorothy Stella Lipinski | . C: T | Nov. | 28, 2005 | |
|) | Examin | er | 44 Febility Neille (17 Not Institution, give street end National) | b. City, Town, or Lo | | 4c. County of Deal | |
| | | | Keswick Multi-Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year | Baltim If Under 24 Hrs. | 8. Date of Birth | n 9 Bird | thplace (State or Foreign |
| | Funeral Director | | 212-56-8124 1 M 2 F 80 Yrs. Months Days | Hours Min. | (Month, Day 11/13 | /25 Mar | yland |
| • | D . | ' | Usuel Residence of Decedent 10a, Stete 10b, County 10c, City, Town or Location | | | | 10d. Inside City Limits |
| | Manyle Fehov | 5 | n-1+3- | more | | | 1 X Yes 2 □ No |
| | 28 | Te l | Md n/a Ball II 10e. Street end Number 10f. Zip Code | | | 10g. Citizen of What Co | ountry? |
| | 23 o o unit | Funeral Director | 700 West 40th Street 212 | | | USA | |
| | r dear | ne | 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of His | ispanic Origin? (Sp n, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - Ame Black, Whit | |
| 2 | s afte | by Fi | 1 ParNever Married 2 ☐ Married 1 ☐ Yes 2 Mar No 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes 2 Married | Specify: | | Specify: W | Thite |
| 3 | is 1 and 2 should be filed within 72 hours after death with the Maryland of Hastin and Mantel Hygiana. If Hastin and Mantel Hygiana. If marked other than "naturel; or items 23e or 28e-f show other traumatic event, the Madical Examiner must be notified at | 8 | | ation | ina | 16b. Kind of Business | |
| 2 | hin 72 | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) | | ing | , | |
| 4 | ed wii | 5 | 8 0 Disable | | e /First Middle | n / a Maiden Surneme) | |
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| | should be filed with and Mantel Hygiana ie marked other thai aumatic event, the | ٩ | Benjamin Lipinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a | | al Route Numbe | r, City or Town, State, | Zip Code) |
| 2 | and 2 s aaith ar n 27 ie ier trau | | Mrs. Mary Quinn / Niece 2133 Pitney | Rd. Pa | rkvill | e, Md. 21 | 234 |
| ע | es 1 a of Had item r othe | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) | e) | Date | 20c. Location - City or | |
| | Peges ment of I ant: if ite ury or of | | 4 □ Donation 5 □ Other (Specify) Bayview Cremat | ory 11/ | 28/05 | Baltimor | e, Md. |
| 0 | permit. Peges 1 and Department of Haaith important: if item 27 any Injury or other tr once. | | 21. Signature of Funeral Service Licensee | | | | en management |
| | 20:00 | | | | | timore, M | |
| | | | 23a. Part1. Enter the disease, or soft plications that caused the death. Do not enter the mode of dying shock, or he art failure. List only one cause on each line. | g, such as cardiac | or rospiratory at | 1001, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition | SYNO | Irome | | Hours |
| | Examiner | | resulting in death) Due to (or es a consequence of): | | 1 | 3 | 1 1 |
| | sit 9d | Examiner | b. mobable wi | inmy | TYACT | injection | - I day |
| | e executed ien and unel-trensit | Хап | Sequentially list conditions, if eny, leading to immediate | | | U | |
| 2 | slcier slcier e bun | = 1 | cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): | | | | |
| 700 | ntificel ng ph | Physician/Medica | resulting in death) Last | | | | - 19 |
| S C | ath ce ttandi | ian | d | | | | |
| 5 | he de | ıysic | Part II. Other significent conditions contributing to death but not resulting in the underlying cause give | en in Pert I. | 23b. Dld 1 | >/ | e to the cause of death? |
| ŗ | that the | by Ph | renal Jachano, cerebral j | palsy | | 22,110 00. | Today, , , , o |
| | ilcian: The law requiras that the death certificate be cartificate has been signed by the attanding physici rector, paga 2 should be datached for use es the bu | Completed b | | | 24a. Wes perfo | an autopsy 24b. rmed? | Were autopsy findings available prior to completion of cause of death? |
| ב | The la ate has paga 2 | lmo: | | | 101 | res 2,200 | 1 ☐ Yes 25 No |
| | artifica octor, I | Be | 25. Was case referred to medical examiner? | 26. Place of Dea | | | |
| 5 | Attanding Physician: ir death. ector: After this cartific by tha funerel director, | 2 | 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Oth 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month. Day Year) Injury Wor | 4 A Nursing H | | dence 6 Other (Spenow injury occurred | ecify) |
| | ding P. h. After funer | tion | | k? Yes 2□No | | | |
| DISINI | or Attanding Faffar death. Director: After din by the funer | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (S City or Tox | Street and Number or F vn, Stete) | Rural Route Number, |
| | To the Hospital or Attanding Physician: The is within 24 hours aftar death. To the Funeral Director: After this cartificate he completely filled in by the funerel director, page | edicai C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time of the control of the death occurred at the time of the control of the control of the death occurred at the time of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th | me, date end place, pinion, death occur | and due to the red at the time, | cause(s) and manner a date and place, and du | s stated. e to the cause(s) |
| | To the Comp | Me | 29b. Signeture and title of certifier 29c. Licens | se number | | 29d. Date signed (Mon | ith, Dey, Year) |
|), | | | Of Harry Pleter, and Od | 2000 | | 100emos | 100,000 |
| ١ | 1 | | 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) A Ricey General McC | harles S | t. Ra | Cfo. and | 21208 |
| | | ate | 31. Dete filed (Month, Day, Year) 32. Registrer's Signature | | | | |
| | Regist | rar | NOV 2 8 2005 | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0.5

20231.

| | | | 1 - For State Registrar | Siai | e or ivia | arytanic | | tificate | | eaith and Death | wentar F | iygier Reg. N | | 30234 |
|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------|------------------------------------|--------------------------------|---------------------------------------|---------------|-------------------------------------------------|------------------------------|------------------------------|--------------------------------------------|---------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle Mich | | | | M -TZ | | | | 2. Date of Month Novem | | 2, 2005 | 3. Time of Death 20:00 M |
| | /Medio Examin | | 4a. Facility Name (If not institution | | d number) | | MCK | night 4b. City, T | own, or | Location of Dea | | | c. County of Death | 20:00 " |
| | / | | University Hosp | | | | | | | timore | | | NANA | |
| | Funeral Director | | 5. Social Security Number 217–68–1950 Usual Residence of Decedent | 6. Sex 1√2 M 2□ | | 9 (In yrs. Ia 48 | st birthday) Yrs. | If Under 1 Months | Days | If Under 24 Hrs Hours Min | . (Month, | Birth Day, Yea 21–5 | r) Cou | place (State or Foreign ntry) Md. |
| | yland | | 10a. State 10b. County | | | 10c. City, | Town or Lo | cation | | | | | | Od. Inside City Limits |
| | 8a-f | Director | Md. | NA | | | Bal | timore | 9 | | | | | 1 🎇 Yes 2 □ No |
| | with the | | 10e. Street and Number | | | | | 10f. Zip (| | | | 10g. C | Citizen of What Cou | ntry? |
| | death ms 23 | Funeral | 1102 Druid Hi | 12. Was | Decedent 8 | | 209 5. 13. V | Vas Decede | | 201 spanic Origin? (| Specify Yes or | No- | USA 14. Race - Ameri | can Indian, |
| 21215-0036 | in 72 hours after death with the Maryland I "neturel", or items 23a or 28s-f ehow kolical Exercipar mark te notified at | δ | 1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced | ed 1 🗆 ` | ed Forces? Yes 21X11 s, Give or Dates: | 10 | | fYes, speci I□Yes 2 <mark>3</mark> | | spanic Origin? (n, Mexican, Pue Specify: | rto Rican, etc.) | | Black, White, | |
| <u>2</u> | 72 hc "netu | eted | 15. Deceden (Specify only highes | 's Education it grade comple | ited) | | (Give | lent's Usual kind of work | k done a | luring most of wo | orking | 16b. | Kind of Business/In | dustry |
| 121 | the the | Completed | Elementary/Secondary (0-12) 11th grade | Colle | ge (1-4or 5 | +) | | sable | |) | | | NTN | |
| | e filed other vent, I | BeC | 17. Father's Name (First, Middle, | Last) | | | | santec | | 18. Mother's Na | me (First, Mide | dle, Maide | NA an Sumame) | |
| <u>X</u> | should be nd Mental marked c | To | John | | | McKn | night | | | Ire | | | Hudson | |
| Maryland | d 2 sh h and 7 Is m treum | | 19a. Informant's Name/Relations Deborah Turne | |) Siste | r | | _ | | nd Number or F Street | | | or Town, State, Zip | Code) 1202 |
| | s 1 and 2 should f Heelth and Mer item 27 Is marke other treumatic | | 20a. Method of Disposition | | DIBLE | 20b. Pla | ace of Dispo | sition (Name | e of | - ! | Date | | Location - City or To | |
| altimore, | e ° = 5 | | 1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | from State | i | metery, cren inity | | ner piaci | · 1 | -29-05 | Dı | ındalk, Mo | d. |
| Balt | permit. Page Department: Important: any Injury 2005. | | 21. Signature of Funeral Service | Licensee | | | | . Name and | Addres | s of Facility | Bal | - | | 21202 |
| | 20 = e a | | 23a. Part 1. Enter the disease, or | complications t | D OU | the death | Do not ont | | | H. East | 110 | l E. | North Ave | enue Approximate |
| | Physician /Medical | | shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | a. | on each lin | ersiv | Car | ele du | السيخ حي | les C | Se-4 | arrest, | | Interval Between Onset and Death |
| | Examiner | | Sacretially lies and disease | 1 b | TO (OI AS | a conseque | ence oij. | | | | | | | |
| | pe tis | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Du | e to (or as | a conseque | ence of): | | | | | | | |
| _^ | rificate be executed og physicien and as the burial-transit | Examin | that initiated events resulting in death) Last | c. Du | e to (or as | a conseque | ence of): | | | | | _ | - | |
| 68760 | icate be e physicier s the buri | ledical E | | d | | | | | | | | | | |
| | | | IF FEMALE: | 1 | | | | | _ | | 20 | | | |
| .O. Box | The law requires thet the death certaile has been signed by the ettendin bage 2 should be deteched for use | Physician/N | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 🗆 L 4 🗆 F | s, outcome Live birth Pregnant at Unknown | 2 Fetal | death 3 | Ectopic pre Other (spe | | | | _ | 23d. Date of deliver Month | ery Day Year |
| Vital Records, P. | quires thet n signed b uid be dete | by | Part II. Other significant condition | ens contributing | to death bi | ut not resul | lting in the ur | nderlying ca | use give | en in Part I. | | d tobacco | use contribute to to | ne cause of death? |
| O S S | e law requir has been si je 2 should l | plete | | | | | | | | | 24a. W | | 24b. Were auto | psy findings available mpletion of cause of |
| ř | | Completed | | | | | | | | | , ₃pe | itopsy orformed? s 2□N | neath? | 2 No |
| Zita Zita | detin: 1 certificel rector, p | Be | 25. Was case referred to medical examiner? | Hoepital- | | | | | Othe | 26. Place of De | | | | |
| | Phys or this aral di | . To | 1 XYes 2 No 27. Manner of Death | 28a. I | 1 Inpatie | ry : | R/Outpatien 28b. Time of | | c. Injury | at | | | 6 ☐Other (Specifical unity occurred) | y) |
| oi Oi | tending l death. tor: After the funer | ation | 1 Accident 5 Pendin | ation | (Month, Day | y Year) | Injury | м | Work 1 □ \ | :? ∕es 2 □ No | | | , | |
| Division of | Hospitel or Attending Physicien: 4 hours effer death. Funerel Director: After this certific tely filled in by the funeral director, | Certification; | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | ined 289. I | Place of Injubulg | ury - At hon c. (Specify) | me, farm, stro | eet, factory, | office | | 28f. Location City or | (Street a Town, Sta | and Number or Rura te) | al Route Number, |
| | To the Hospitel or At within 24 hours effer of To the Funerel Direct completely filled in by | Medical (| | and | o the best of the basis of manner sta | of my know examination sted. | vledge, death on and/or inv | occurred a restigation, i | it the tim | e, date and place pinion, death occ | e, and due to the time | he cause(i.e. date a | s) and manner as s nd place, and due to | tated. o the cause(s) |
| | To the I within 2 To the I complet | ≥ | 29b. Signature and title of certifie | 0000 | . ^ | | | 29c. | | number .C.M.E. | | | ate signed (Month, | |
| | J, | | 1 Clori | rell | U) | | nn-1 ~ | 1 | U. | . C.M.E. | | NOA | ember 23, | 2000 |
| | 1X | | 30. Na and address of person | who completed | vause of d | eath (Item) | 111 F | enn S | | et, Balt | imore, | Mary | land 2120 |)1 |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | g 2005 | 32. Registra | ar's Signati | ure A | mili | | | | | | |

| | | 4 | For State Registrar | State of Maryla | | ertificate of | | | 2005 | 38235 | | | | |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------|--------------------------------------------|-----------------------------------------------------------|--|--|--|--|
| | Physici /Medic | _ | Decedent's Name (First, Middle, Last PEGGY | J. | | MILLS | | 2. Date of Death Month | 25 2005 | | | | | |
| } | Examin | | 4a. Facility Name (If not institution, give | | TAC | 4b. City, Town, o | TMORE | | 4c. County of Dea | ath | | | | |
| | Funeral Director | | 300-32-7009 | ex 7. Age (In yrs | . last birthda Yrs. | y) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 1 | | nthplace (State or Foreign Country) N.C. | | | | |
| | Maryland -f show | tor | Usual Residence of Decedent 10a. State 10b. County Md • | NA 10c. C | ity, Town or | Location Ltimore | | | | 10d. Inside City Limits 1 Yes 2 No | | | | |
| | th with the 23s or 28s | Funeral Director | 10e. Street and Number 5032 Woodmont | | | 10f. Zip Code | L239 | 100 | g. Citizen of What C | | | | | |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGE. | by | 11. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: | U.S. 13 | 3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ▼ No | dispanic Origin? (Specan, Mexican, Puerto F Specify: | cify Yes or No- lican, etc.) | 14. Race - Am Black, Wh Specify: | | | | | |
| Maryland 21215-0036 | in 72 ho in "natur Wedical | Completed | 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) | ducation de completed) College (1-4or 5+) | 16a. Dec (Giv life | cedent's Usual Occup ve kind of work done DO NOT use retire | oation during most of workin d) | g 16 | 6b. Kind of Business | s/Industry | | | | |
| 1212 | led with tygiene her the | Com | 12th grade 17. Father's Name (First, Middle, Last) | | 0: | ffice Mana | ager 18. Mother's Name | | Rubber St | amp Co. | | | | |
| /lanc | uid be f Mentai H rrked ot | To Be | Jack | | Slade | | Katie | (Frist, Wildule, Wil | | ndley | | | | |
| Mary | id 2 sho th and A 27 is ma trauma | i | 19a. Informant's Name/Relationship (Nikki Mills | Type, Print) Daughter | | - | and Number or Rural Avenue, Ba | | • | Zip Code) 202 | | | | |
| ore, | ges 1 ar t of Hea if item or other | 1 18 | 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ | 20b. | | position (Name of rematory or other pla | | | Oc. Location - City o | | | | | |
| altimore, | permit. Pa Departmen Important: any injury 2009. | | * 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer | y) <u>F</u> | | em. Park 22. Name and Addre | 11-29 ess of Facility | Baltimo | Randallst re, Md. | 21202 | | | | |
| m = | 88 28 | | 23a Parti Enter the disease or for | blications that caused the day | ath Do not e | March F.F | | | . North A | Ve - | | | | |
| | Physician /Medical | | 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lime limited linears or condition resulting in death) a. CEREBARL ANOXIA Due to (or as a consequence of): | | | | | | | | | | | |
| | Examiner | L. | Sequentially list conditions, | b. BILATE | RAL | ISCHE | MIC 5 | TROKE | \$ | | | | | |
| | ocuted nd transit | Examiner | any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | c. ATETAL | F | BRILLA | DON | | | | | | | |
| 68760, | tificate be executed ig physician and as the burial-transit | Medical Ex | resulting in death) Last | Due to (or as a conse | quence of): | | | | | | | | | |
| | certific nding p | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregi | nancy | | | | 23d. Date of de | alivery | | | | |
| P.O. Box | res that the death cer igned by the attendir be detached for use | Physician/ | in the past 12 months? 1 Yes 2 No 9 Unknown | 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown | | B □Ectopic pregnancy □ Other (specify) □ | у | | Month | Day Year | | | | |
| | w requires that been signed I should be det | b | Part II. Other significant conditions of | ontributing to death but not re | sulting in the | underlying cause giv | ven in Part I. | | _ | to the cause of death? | | | | |
| Il Records, | e la has | Completed | | | | | | 24a. Was an autopsy performe 1 Yes 2 | prior to death? | utopsy findings available completion of cause of s 2 🔀 No | | | | |
| Vita | sician: Th certificate irector, pag | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No | Hospital: 1 Inpatient 2 | □ ER/Outpati | ent 3 DOA Oth | 26. Place of Death | | ce 6 □Other (Spe | agifu) | | | | |
| Division of Vital | nding Phy th. r: After this e funeral d | ation: To | 27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time Injury | of 28c. Injui | 4 🗆 Nuising Hom | 8d. Describe how | | ecity) | | | | |
| Divis | al or Attents after death | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | 21 | 8f. Location (Stre City or Town, | et and Number or R State) | lural Route Number, | | | | | | | |
| | To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the | edical | 29a. Certifying Ph (Check only one) 1 Certifying Ph 2 Medical Exer | ysician: To the best of my kr niner: On the basis of examir and manner stated. | nowledge, de nation and/or | ath occurred at the til investigation, in my o | me, date and place, and place, and ppinion, death occurred | nd due to the cau d at the time, date | ise(s) and manner a e and place, and du | s stated. e to the cause(s) | | | | |
| | Tot withi Totl | W | 29b. Signature and title of certifier | ABOUGERGI, N | 10 | 29c. Licens | se number | 290 | d. Date signed (Mon $11/26/c$ | | | | | |
| | Ŋ | | 30. Name and addies of person who MARWAN ABOU | completed cause of death (Ite | em 23a) (Typ | e, Print) SAM | IAKITAN | l lates f | THE | | | | | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | GERGI, MD 32. Registers Sign 9 2005 | nature | L. South | | | 4.00 | | | | | |
| | *** | | 110° | 9-3-3-1 | | 4 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38236 For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 45 AM **Physician** 49014 KED /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD FORE MACHINA Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Min 1□M 2ØF Yrs 213-14 ARUL GUA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "neturel", or leams 23s or 28a-f show treumatic event, the Medical Evantracturist be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should ba filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IAL ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is 1 MD 2903 REYSUILLE other 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 ₽ Burial 2 □ Cremation 3 Removal from State ò permit. Page Department of Importent: If any injury or once. KEL AIR MEMBRIAL 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evants Function CLADEL. EUTERI 1 23a. Part1. Enter the disease on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YPERTENS. OF /Medical Due to (or as a consequence of): Examiner OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequençe of) Physician/Medical Examiner The law requiras that the death certificate be executed as the burial-transit 71 Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 24 No , page 2 s 1 ☐ Ýes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home esidence 6 Other (Specify) ၉ 1 Inpatient this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending 2 🗌 No 1 Tyes investigation death. Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, To the Hospitel or Attending Physician: 24 hours a To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 ナレナン 31. Date filed (Month, Day, Year) 32.

State Registrar

Medical

9 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 05 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician Andrew T. Manlove 2005 7:25 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAR 8, 1964 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1**X**M 2□ F 41 Yrs. Minnesota 213-94-7517 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ms 23s or 28a-f show 1 ☐ Yes 2 No Director Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 814 E. Joppa Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or iten any injury or other traumatic event, the Medical Examinar page. 1 Yes 2 XNo ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify. White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Print Shop Folder 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marilyn J. Patrick John G. Manlove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21286 814 E. Joppa Road John G. Manlove/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/25/05 Baltimore, MD 21. Signatur of Fu eral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. Edward A. Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTRIC 8 Mouths **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 pe Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Dav 4☐Pregnant at time of death 5 Other (specify) _ 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably eted 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Compl autopsy 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation al or Attend after death Director: in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
NOV 2 9 2005

Faulkner MD/660) N Chadestreet,
9 2005 32 Jugistrar's Signature

April

| | 3 = 5 = - | | For State Registrar | State of Maryland | | artment of H | | /lental Hygier Reg. N | | 38238 |
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| | Physicia /Medic Examin | al | 1. Decedent's Name (First, Middle, Helen 4a. Facility Name (If not institution, Harbor H | give street and number) | ey | 4b. City, Town, or Ball | Location of Death | November | 26 2001 4c. County of Dea | |
| 4 | Funeral Director | | 5. Social Security Number 215-09-0564 Usual Residence of Decedent | 6. Sex 7. Age (In yrs. Ia 1 M 2 M F 92 | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Feb. 16, 19 | 13 Per | thplace (State or Foreign puntry) INSYIvania |
| | a-f ahow | ctor | 10a. State 10b. County Maryland N/A | | rookly | | | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| | h with the | ai Dire | 10e. Street and Number 619 Annabell Av | /enue | | 10f. Zip Code 21225 | ; | | Citizen of What Co | ountry? |
| 980 | within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f ahow ta Majical Examinar must be notified at | by Funer | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U.S Armed Forces?/ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 17 No | spanic Origin? (Sp n, Mexican, Puerto Specify: | pecify Yes or No- Rican, etc.) | 14. Race - Ame Black, Whi Specify: Wh | te, etc. |
| 21215-0036 | be filed within 72 hours after death with the Marylar ital Hyglene. Id other than instural, or flems 23s or 28s-f show event, it a Musical Examination must be notified at | Completed by Funeral Director | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | grade completed) College (1-4or 5+) | (Give lite. i | dent's Usual Occupa kind of work done o DO NOT use retired, SEWIFE | furing most of work | king | Kind of Business Home | /Industry |
| Maryland | | To Be | 17. Father's Name (First, Middle, L | arvis | | | Elizabe | | angaitis | |
| Baltimore, Mar | Pages 1 and 2 should nent of Health and Mer ant: If item 27 Is marke ary or other traumatic | | 19a. Informant's Name/Relationsh Intoinette Hardes 20a. Metylod of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | sty (Daughter) 3 □Removal from State | 310 N lace of Dispo emetery, crer | orth Hamm sition (Name of natory or other place | onds Fer | | | Maryland Town, State |
| Baltir | permit. Par Departmen Important: any Injury | 4 | 21. Signature of Funeral Service L | icense | / Mc | . Name and Addres | s of Facility yniak Fu | neral Home | P.A. | 2122 |
| 760, 0 | Physician /Medical Examiner physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physicia | icai Examiner | 23a Part. Enter the disease, or o shock, or heart failure. List of the shock of heart failure. List of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the shock of the sh | - Congé | uence of): Sin uence of): | er the mode of dying e Hea | , | -ailur | | Mappy And Appy Chinate Interval Between Onset and Death YEAVS |
| .O. Box 68 | death certific e attending pl d for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknowh | 23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of de Month | livery Day Year |
| ٥. | s th | ٥ | Part II. Other significant condition | ns contributing to death but not resu | ulting in the u | nderlying cause give | en in Part I. | | | o the cause of death? robably 4 Unknown |
| of Vital Records, | | Completed | | | | | | 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ | prior to | utopsy findings available completion of cause of |
| of Vit | Phys this al dii | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death | | ER/Outpatier | | er: 4 🗆 Nursing H | th Check on one ome 5 Residence 28d. Describe how in | | эсібу) |
| Division | Attending death. | ertification: | 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determin | ation of be as Sleep of Injury. At he | Injury ome, farm, str | M 1 🗆 🗅 | Yes 2 □ No | 28l. Location (Street City or Town, St. | and Number or R | tural Route Number, |
| _ | Hospit 4 hour Funera ely fille | edical C | 29a. Certifier 1 Certifying (Check only one) | Physician: To the best of my know xaminer: On the basis of examinat and manner stated. | wledge, deat tion and/or in | h occurred at the tim vestigation, in my op | ne, date and place pinion, death occu | , and due to the cause rred at the time, date a | (s) and manner a and place, and du | s stated. e to the cause(s) |
| | To the within 2. To the f | Me | 29b. Signature and title of certifier | 11 | | 29c. License | | | Date signed (Mon | |
| , | 5 | | 30. Name and address of person v | who completed cause of death (Item MASTELLONE | 23a) (Type, | Print) 3001 S | outh t | tanover | Stran | r 26 2005 |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | 32. Segistrar's Signal | ture | | | | SITEE | |

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Richard Thomas Moxley Sr. Month 11 Day 24 Year 05 **Physician** 11:59 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 07-31-1923 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 82 yrs. 6. Sex 1 M M 2 ☐ F **Funeral** Director Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore Catonsville 1 Yes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 719 Maiden Choice Lane BR-511 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic access. 5+ College (1-4or 5+) Elementary/Secondary (0-12) Private Practice Attorney 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret Cashen 17. Father's Name (First, Middle, Last) Be Charles J. Moxley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane BR511 Catonsville, MD 21228 Rita Edith Moxley-wife 20c. Location - City or Town, State 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11-26-2005 Baltimore, Maryland ` 4 ☐ Donation 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 1630 Edmondson Ave. Catonsville Witzke Funeral Home of Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Justodysplastic Du (or as a consignation of): disease or condition resulting in death) anomia rears /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 1 Yes 2 No 1 Yes tal or Attending Phyaician: Tis after death.
al Director: After this certificate ed in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 10 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours a To the Funeral C Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30989 yla MCc November 25 2005 30. Name (n address of person who completed cause of death (Item 23a) (Type, Print) Myla M Carperter
31. Date filed (Month, Day, Ye) MD 711 Maiden Choice In Catonsville MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

| Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Joseph Oliver Murphy 4a. Facility Name (If not institution, give street and number) 104 Rosewood Ave. Catonsville 5. Social Security Number 213-30-8188 128M 2 F 71 Yrs. Director Usual Residence of Decedent 2. Date of Death Month Day November 27, 20 4b. City, Town, or Location of Death Catonsville Catonsville Baltin Aprili Day Year 1934 Usual Residence of Decedent | of Death nore 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No That Country? States - American Indian, |
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| 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - (cemetery, crematory or other place) | City or Town, State |
| Lake View Mem. Park Dec. 1, 2005 Sykesv | ille, Maryland |
| 1030 Edmondson Ave., Catonsville, | MD 21228 |
| 23a. Part 1. Enter the disease, or complications that ca)sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. | Approximate Interval Between Onset and Death |
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| D35254 11-28- | (Month, Day, Year) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Complete to Miller MO 9005 (2th) 200 BALTUM (Item 23a) | M 21229 |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature | |
| Registrar DHMH 17 Rev 1/2001 | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** Robert Edward Macdonald VOVEMBER 23, 2001 17:11 M /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** BALTIMURE SAINT AGNES HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

07-31-1922 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1**∑**M 2□F 83 Massachusetts 021-16-1690 Yrs. Director Usual Residence of Decedent 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits itam 27 is merked other than "natural", or itams 23a or 28a-f ahow other traumatic avant. The Madical Examinar must be notified at MDBaltimore Catonsville 1 ☐ Yes 2 ▼No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 2 Winesap Court Apt.B USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itam any injury or other traumatic avent, the Meutical Examinat. Once. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Salesman Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Edward Macdonald Jessie MacInnis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Winesap Court Apt.B Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print, Elaine Macdonald -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-26-2005 Catonsville, MD 21228 Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature a Funeral Service Livens 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heart disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) MAR DUNKLO, KOBERT Division of Vital Records, P.O. by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 🗌 Yes 1 TYAS 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attanding Injury 1 KNatural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a To the Funeral D 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061564 1401 Are, Baltimore, MO State NOV 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygier [] 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year **Physician** Dhen eno November 272005 /Medical Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death street and number) Examiner Istow thwes more L 0 VI OY If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 54 Director 216-74-5687 02. 23. 1951 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Madical Examinar must be notified at 1 Yes 2 KNo Directo BALTIMORE PIKESVILLE MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? WAY USA 1611 WOODLING 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after intent of Health and Mental Hygiene. ent: If Item 27 Is marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CRAFIS RETAIL 12 1H GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOE MCLENDON FANNIE MCCLENDON ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONYA ANDERSON 3204 BURNBROOK LANE BALTIMORE MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of h
Importent: if ite
eny injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS 4 ☐ Donation 5 ☐ Other (Specify) 12.02.05 BALTIMORE. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE ans 5151 BAUD. NATE PIKE BAUTO. MO 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician mona 000 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical use as the y the attending priched for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peeq 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No certificate 1 Yes 1 Yes Division of Vital To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes > No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a
To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 a 30. Name and address of person who completed of ause of death (Item 23a) (Type, Print) Koad NWHC 540 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

UNK, UNK Steven Minerak

05-07716

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | For | State of Maryland / Department of Health and M Certificate of Death | Mental Hygiene | 2021 |
|-----|--------------------------------------|----------------------------------------------------------------------|------------------|----------------|
| - | State Registrar | Certificate of Death | Reg. No. | 3024 |
| . D | ecedent's Name (First, Middle, Last) | | 2. Date of Death | 3. Time of Dea |
| C | * T M | • • | Month Day Year | |

| CT | · · · · · · · · · · · · · · · · · · · |
|----|---------------------------------------|
| | Physician |
| | /Medical |
| | Examiner |

1

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, if a Medical Evants or must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760, 🥕

| Steven Lee Menneric | K | | Novembe | r 15 200 |)5 5:45 A M | | | |
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| 4a. Facility Name (If not institution, give street | t and number) | 4b. City, Town, or Location of De | | 4c. County of Death | | | | |
| St. Agnes Hospital | | Baltimore | | | | | | |
| Social Security Number 6. Sex | 7. Age (In yrs. last birthda | | lrs. 8. Date of Birth (Month, Day, May 8, | a Ri | rthplace (State or Foreign | | | |
| 215-70-1172 | | Months Days Hours M | 1956 Ms | iryland | | | | |
| Usual Residence of Decedent | | | nay 0, | 1730 | T y Land | | | |
| 10a. State 10b. County | 10c. City, Town or | Location | | | 10d. Inside City Limits | | | |
| i MD D 1 | | | | | 1 ☐ Yes 2 🖾 No | | | |
| MD Baltimore 10e. Street and Number 127 Garden Ridge 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only highest grade come (Specify only hi | Catonsv | ille | | | 1 1 1 1 6 3 2 1 1 1 1 0 | | | |
| 10e. Street and Number | | 10f. Zip Code | 11 | 0g. Citizen of What C | ountry? | | | |
| 127 Garden Ridge | | 21228 | U | nited Stat | es | | | |
| 11. Marital Status 12. W | Vas Decedent Ever in U.S. 1. | 3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu | (Specify Yes or No- | 14. Race - Am | erican Indian. | | | |
| 1 Never Married 2 Married 1 | med Forces? ☐Yes 2 14No | If Yes, specify Cuban, Mexican, Pu | erto Rican, etc.) | Black, Wh | te, etc. | | | |
| 3 ☐ Widowed 4 🖺 Divorced Y | Yes, Give ear or Dates: | 1 ☐ Yes 2 ☐ No Specify: | | Specify: W | hite | | | |
| 15. Decedent's Education | 16a De | cedent's Usual Occupation | | 10h Kind of Business | n - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - | | | |
| (Specify only highest grade con | npleted) (Gi | ve kind of work done during most of w b. DO NOT use retired) | vorking | 16b. Kind of Business | vindustry | | | |
| Elementary/Secondary (0-12) C | ollege (1-40r 5+) | | | | | | | |
| 17.5 | 1 | ree Cutter | | Landscapir | ıg | | | |
| 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) | | | | | | | | |
| Ralph Leroy Mennerick, Jr. Frances Adams | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, P | rint) 19b. Ma | iling Address (Street and Number or | Rural Route Number, | City or Town, State, | Zip Code) | | | |
| Barbara Larocki | | Dock Road: West | | | | | | |
| 20a. Method of Disposition | 20b. Place of Dis | position (Name of | | 20c. Location - City or | | | | |
| 1 ☐ Burial 2 ဩCremation 3 ☐ Remov | al IIUII State | position (Name of rematory or other place) | | • | | | | |
| 4 □ Donation 5 □ Other (Specify) | | | | Falls Chur | | | | |
| 21. Signature Fur ral Service Icensee | | 22. Name and Address of Facility Witzke Funeral H | | | _ | | | |
| CARAN- | | | | | Inc. | | | |
| 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call | ns that caused the death. Do not e | inter the mode of dying, such as cardi | ac or respiratory arre | est. | Approximate | | | |
| 1 | | | | | Interval Between Onset and Death | | | |
| disease or condition resulting in death) | omplications = | of chronic al | coholish | ^ | 3.100. 4.10 204.11 | | | |
| resulting in death) | Due to (or as a consequence of): | | | | | | | |
| Sequentially list conditions. | | | | | | | | |
| | Due to (or as a consequence of): | | | - | | | | |
| Cause (Disease or injury that initiated events | | | | | | | | |
| soculting in doath) Lost | Due to (or as a consequence of): | | | | | | | |
| | | | | | | | | |
| d | | _ | | | | | | |
| IF FEMALE: | | | | | - | | | |
| 23b. Was decedent pregnant in the past 12 months? | yes, outcome of pregnancy □Live birth 2 □ Fetal death 3 | ☐Ectopic pregnancy | | 23d. Date of de | - / | | | |
| 1 ☐ Yes 2 ☐ No 41 | | Other (specify) | | Month | Day Year | | | |
| 9 ☐ Unknown | | | | | | | | |
| Part II. Other significant conditions contribut | ing to death but not resulting in the | underlying cause given in Part I. | 23e. Did toba | acco use contribute to | the cause of death? | | | |
| | | | 1 ☐ Ye | s 2 No 3 Pr | obably 4 Dunknown | | | |
| | | | | | | | | |
| | | | 24a. Was an autopsy | prior to | topsy findings available completion of cause of | | | |
| | | | perform 1 X Yes 2 | ed? death? □ No 1 1 1 1 Yes | | | | |
| 25. Was case referred to medical | | 26. Place of De | eath (Check only one | | | | | |
| examiner? ★XYes 2 No Hospita | al: XIX Inpatient 2 ER/Outpati | Other | | nce 6 Other (Spe | 7.6.1 | | | |
| | a. Date of Injury 28b. Time | of 28c. Injury at | 28d. Describe how | | Jny) | | | |
| 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) Injury | Work? M 1 ☐ Yes 2 ☐ No | | ,, | | | | |
| 2 Could not be | Diagonal Indiana Abbassa 6 | | | | | | | |
| 4 Homicide determined 286 | Place of Injury - At home, farm, s building, etc. (Specify) | treet, factory, office | 28f. Location (Stre City or Town, | eet and Number or Ru State) | ıral Route Number, | | | |
| | | | | | | | | |
| 29a. Certifier (Check only XX Medical Examiner: O | To the best of my knowledge, dea | th occurred at the time, date and place | e, and due to the cau | use(s) and manner as | stated. | | | |
| one) | nd the basis of examination and/or and manner stated. | nvestigation, in my opinion, death occ | curred at the time, dat | te and place, and due | to the cause(s) | | | |
| 29b. Signature and title of certifier | | 29c. License number | 290 | d. Date signed (Monti | n, Dey, Year) | | | |
| hij his n | Din | OCME | NT. | orrombon 15 | 2005 | | | |
| , , , | | OCLIE | 100 | ovember 15 | , 2005 | | | |
| 10. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI MIN 111 Penn Street Baltimore, Maryland 21201 | | | | | | | | |
| 1 11 1 | ed cause of death (Item 23a) (Type | | | | | | | |

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2005

| 1 | | | 1- State of Maryland / Department State of Maryland / Department Certification | ent of Health and Menta ate of Death | / | 11115 | 38244 |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------|----------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | 2. Dat | Reg. Note of Death | J | 3. Time of Death |
| ı | Physici | | Louise B. Martin | No. | ember 2 | , | 1900 M |
| 1 | /Medi Examir | | | ly, Town, or Location of Death | - | County of Death | 1.900 |
| | | | University Hospital B | altimore | | | |
| | Funeral | | Month | ler 1 Year If Under 24 Hrs. 8. Dat s Days Hours Min. (Mo | e of Birth onth, Day, Year, | 9. Birthp | place (State or Foreign |
| | Director | | Usual Residence of Decedent | Octol | ber 30, | 1921 Penr | nsylvania |
| | land ow | | 10a. State 10b. County 10c. City, Town or Location | | | 1 | 0d. Inside City Limits |
| | Many Feb | ģ | MD Montgomery Rockville | | | | 1. TYes 2 No |
| | h the | irec | | Zip Code | 10g. Ci | itizen of What Cour | |
| | th wil | a D | 9809-1 Veirs Drive 2 | 0850 | Unite | d States | of America |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Modical Examination minister notified at once. | by Funeral Director | Aggred Forces? If Yes, sp | edent of Hispanic Origin? (Specify Ye pecify Cuban, Mexican, Puerto Rican, ε 2 Δ Νο Specify: | es or No- etc.) | 14. Race - Americ Black, White, Specify: Whi | etc. |
| 2 | 72 ho | Completed | 15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of | sual Occupation work done during most of working | 16b. K | (ind of Business/Ind | dustry |
| 2 | Aithin | m fd | Elementary/Secondary (0-12) College (1-4or 5+) | use retired) | | | |
| | lled w tygie her ti | | 17. Father's Name (First, Middle, Last) | ered Nurse | | sing Indu | ıstry |
| anc | ntal Hed of | Be | | 18. Mother's Name (First, | middle, Maider | n Sumame) | |
| $\frac{3}{2}$ | hould d Me mark mark | Z | John Burnett: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre | Louise Pry ass (Street and Number or Rural Route | . Norther City | an Tarras Chana Tia | 0-1-) |
| Maryland | d 2 s th an t7 is r traus | | | | | | |
| | 1 an Heal tem 2 | | 20a. Method of Disposition 20b. Place of Disposition (A | lame of Date | 20c. L | ter, Mary | Tand 21158 |
| ē | ages ant of it: if it | | 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Common State** **Common State** **Metro Cremator** **Common State** **Metro Cremator** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** **The Common State** | | l l | Box 2966 | - |
| Baltimore, | permit. F Departme Importan any Injur | | 21. Signature of Funeral Service) Licensee 22. Name | and Address of Facility Loring Liberty Road, Rand | Byers 1 | Funeral D | irectors, Inc |
| | 4028 0 | | 23a. Rent : Enter the disease, or complications that caused the death. Do not enter the m | | | wn, maryı | |
| E | | . 115 | snock, or heart failure. List only one cause on each line. | ode of dying, such as cardiac or respira | atory arrest, | | Approximate Interval Between Onset and Death |
| 1 | Physician / /Medical | | Immediate Cause (Final disease or condition resulting in death) | 5 | | | 0.000, 2.10 002, |
| | Examiner | | Due to (or as a consequence of): | | | | |
| | | in lie | Sequentially list conditions, if any, leading to minisolate cause. Enter Underlying | | | | |
| | uted 1 ansit | 듣 | Cause (Disease or injury | | | | |
| ~ | execunation and ial-tra | Examiner | that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | |
| 8/60, | icate be executed physicien and s the burial-transit | dical | d. | | | | |
| P | | (D) | | | | | |
| P.O. Box | The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as it | Physician/M | IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic 4 ☐ Pregnant at time of death 5 ☐ Other (| | | 23d. Date of delive Month | Day Year |
| | w requires that been signed t should be deta | by | Part II. Other significant conditions contributing to death but not resulting in the underlying | cause given in Part I. 236 | | use contribute to the | e cause of death? |
| Division of Vital Records, | | Completed | | | a. Was an autopsy performed? | prior to con death? | osy findings available inpletion of cause of 2 No |
| <u> </u> | Attending Physician: Thir death. ector: Atter this certificete by the funeral director, pag | Be | 25. Was case referred to medical examiner? | 26. Place of Death (Check | k only one | | |
| 0 | Phys this al dir | P | 1 Syes 2 No Hospital: 1 ☐ Inpatient 2 € ER/Outpatient 3 ☐ I 27. Manner of Death 28a. Date of Injury 28b. Time of | | | | /) |
| | ding h. After funer | Certification: | 1 □Natural 5 □ Pending (Month, Day Year) Injury | Work? | scribe how inju | | 0000000 |
| S | or Attendated of a file of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the count | ical | 3 Suicide 6 Could not be | Disto | | nd Number or Rura | DED WITH CAR |
| 2 | i or dafter Dire | ert | building, etc. (Specify) | City | or Town, State | 9). | |
| | Hospital 24 hours Funeral etely filled | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre | d at the time, date and place, and due | to the cause(s |) and manner as st | Annou Ory |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical | (Check only one) Medical Examiner: On the basis of examination and/or investigation and manner stated. | n, in my opinion, death occurred at the | e time, date and | d place, and due to | the cause(s) |
| | To the Hospital or within 24 hours affer To the Funeral Dir completely filled in I | Me | 29b. Signature and title of certifier | 9c. License number | 29d. Da | te signed (Month, L | Day, Year) |
|) | 0 | | Maydera (In Mhol um | OCME | Norre | ember, 26 | 2005 |
| ì | 0 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | OOTH | TAOAE | EMDEL , ZO | . 2007 |
| _ | V | | MARGARITA BIKOREL 1 | 111 Penn Street B | Baltimor | ce, Maryl | and 21201 |
| | Sta | | 21 Data filed (Month Day Veer) | | | | |
| | Registr | ar | NOV 2 9 2005 | | | | |

| | | | For State Registrar | Amend Ite | n 23a per | aryland Dr.,G | 349epa Cer | Then of 129/05di | leaith an Death | d Mental F | lygien Reg. No | 005 | 3824 | 5 |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------|-----------------------------------------|--------------------------|---------------------------------|----------------------------------------------------|-----------|
| | Physici | | 17 | ame (First, Middle, La | | 1+0: | | | | 2. Date of Month | Death Da | iy Yea | | |
| | /Medio Examin | | | | re street and number) | 121 | | 4b. City, Town, o | or Location of D | Death NOVE | | County of De | ath 1540 |) |
| | Funeral | 3 | 5. Social Securit | Memor ty Number 6. | | (In yrs. las | st birthday) | If Under 1 Year | If Under 24 | | Birth | N/A | irthplace (State or For | eian |
| | Director | | 220 - 64 Usual Residence | 1 10 1 4 | 1 ∑ M 2□F | 83 | Yrs. | Months Days | Hours A | 3 - 7 - | Day Year | - | inidad | -3. |
| | iryland show | _ | 10a. State | 10b. County | | | Town or Loc | | | | | | 10d. Inside City Lin | nits |
| | the Ma | Director | Md 10e. Street and | Number Number | | 13a | /fi'm | 10f. Zip Code | | | 10g Ci | tizen of What (| 1 XYes 2 | No |
| | ath with | ral DI | 1720 | E. 32n | d St. | | | | 18 | | | U.S.1 | 4. | |
| 99 | within 72 hours after death with the Maryland jiene. rithan "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at | / Funeral | | larried 2 Married | 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give | | If | /as Decedent of H Yes, specify Cub ☐ Yes 2 ☑ No | lispanic Origin? an, Mexican, Pi Specify: | ? (Specify Yes or uerto Rican, etc.) | No- | 14. Race - Arr Black, Wh | | |
| 21215-0036 | 2 hours atural', cal Exe | ted by | | d 4 Divorced 15. Decedent's E | Year or Dates: | | 16a. Decede | ent's Usual Occur | pation | | 16b. 8 | Specify: 13/ (ind of Busines | ack s/Industry | |
| 1215 | within 7; ene. than "n | Completed | | pecify only highest gr econdary (0-12) | ade completed) College (1-4or 5 | | (Give k | ind of work done O NOT use retire | during most of | working | // | / . / | / | |
| | il Hygie other i | au I | 17. Father's Nan | ne (First, Middle, Last |) | | Hous | excep | 18. Mother's | Name (First, Midd | lle, Maider | Semame) | a/ | |
| Maryland | should be nd Mental marked c | To B | Paul | UD 40 | attei | | | | Mari | | coux | | | |
| | nd 2 | | Franc | Name/Relationship (| lype, Print) | 1197 | 2002 | Address (Street | and Number of | r Rural Route Nun | t 4 | Polls | Zip Code) 2/23 | 9 |
| ore | Pages 1 a nent of Hee int: If Item iry or othe | | | 2 Cremation 3 | Removal from State | 20b. Plac | | ition (Name of atory or other plan | · / | Date | 20c. L | ocation - City o | r Town, State | |
| Baltimore, | 글 돈 뿐 글 | | - | n 5 □ Other <i>(Speci</i> Funeral Service Lice | | Gard | | Name and Addre | ss of Pacility | 1, 30, 2005 | 100 | ervice | R.A | - |
| | Deprillimpo | | Ca | elfun C | . Dougle | us | 17 | 11 McCul | loh st. | Bulh. | Ud. | 212/ | | |
| | Physician | | Immediate Caus | neartrailure. List only se (Final | plications that caused one cause on each li | 10. | | | ig, such as card | diac or respiratory | arrest, | | Approximate Interval Between Onset and Death | |
| | /Medical Examiner | | disease or cond resulting in deat | th) | a. Due to (or as | a consequer | | RY | FAIL | MRE | | | 10 Hou | RS |
| NE. | | Jer | Sequentially list if any, leading to cause. Enter Ur | conditions, immediate | b. LARCE Due to (or as | a consequer | nce of): | | | moni | A | - | II DA | 25 |
| | ecuted and I-transit | Examiner | Cause (Disease that initiated ever resulting in death | or injury | c. Due to (or as | 2 | TION | piration - | Pneumo | nia | | | -11 Bry | 2 |
| 68760, | ficate be executed physicien and is the burial-transit | edical E | | | d | a conseque | 10 0 01). | | | | | | | |
| | | /Med | IF FEMALE: | | 23c. If yes, outcome | of pregnance | | | | | | | | |
|). Box | The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as | Physician/M | 23b. Was deced in the past 1 ☐ Yes 9 ☐ Unknown | 12 months? 2 \(\subseteq No | 1 Live birth 4 Pregnant at | 2 Fetal de | eath 3 E | ctopic pregnancy Other (specify) | | | | 23d. Date of de Month | olivery Day Year | |
| P.O. | that the de ned by the a detached f | | | | contributing to death b | ut not resultin | ng in the unc | lerlying cause giv | en in Part I. | 23e. Dio | tobacco i | use contribute t | o the cause of death? | , |
| ords | w requires been sign should be | ted by | HYPER | CTENSI | CA) | | | | | _ 10 | Yes 2 | □ No 3 🖫 🗜 | fobably 4 □Unkno | wn |
| Rec | he taw e has by ige 2 st | Completed | | L FIBRI | LATION | ANT | D E | LUTTE | R | 24a. We | s an opsy formed? | 24b. Were a prior to death? | utopsy findings availa completion of cause (| ble of |
| ita | ding Physicien: The In. After this certificate he funeral director, page | BeC | 25. Was case re examiner? | ferred to medical | | | | | 26. Place of I | | 2 110 | | s 20140 | |
| ot \ | Physic this c | ၉ | 1 Yes 2 | | Hospital: 1 Hipatie | | VOutpatient | | 4 U Nursing | g Home 5□Re | | | ecify) | |
| Division of Vital Records, | I or Attending Physicien: after death. Director: After this certifics i in by the funeral director, i | atlon | 1 Natural 2 Accident | 5 Pending investigation | (Month, Day | Year) | Injury | 28c. Injur Worl M 1 | /at k? Yes 2 □ No | 28d. Describe | how injur | y occurred | | |
| Divis | after deat after deat Director: d in by the | Certification: | 3 ☐ Suicide 4 ☐ Homicid | 6 Could not b determined | | iry - At home c. (Specify) | e, farm, stree | et, factory, office | | | (Street an own, State | | ural Route Number, | |
| | To the Hospitel of within 24 hours af To the Funerel D completely filled in | edical C | 29a. Certifier (Check only one) | 1 Certifying Ph 2 ☐ Medical Exar | nysician: To the best of | examination | edge, death of and/or inve | occurred at the tin | ne, date and pla | ace, and due to th | e cause(s) | and manner a | s stated. | |
| | within 2 To the comple | Med | | nd title of certifier | and manner sta | ted. | | 29c. License | | | | e signed (Mon | | |
|) | | | 1 | latet | 5/ | mp | | ATZ | 4380 | 146 | 11 | 124 | 12005 | |
| | 4 | | 30. Name and ac | | ERIPP | 1.11 | 7 | | LNWE | RSITT | PICI | 77 E | 2 ALTINAS | 0 |
| | Stat Registra | | 31. Date filed (M | lonth, Day, Year) | 22. Registra | r's Signature | Good | | | | 1 (0.0 | | ND ZIZI | 8 |
| DLA | 41.17.0-1/00 | 04 | N | OV 2 9 200 | - Miller | 10. | A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 05 38246 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11-20-2005 **Physician** 4:30 A M Ernestine Josephine Murphy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Hammond's Lane Anne Arundel Brooklyn | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | 8-6-1928 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director MD 213-24-7949 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r then "neturel", or items 23s or 28e-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Queen Annes Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21619 USA 2727 Cecil Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes XXNo White Specify: ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne eny injury or other treumatic event, Ita Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Cook Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES EDWARD MOORE MARY ADA BUSSARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice M. Webb / Daughter 2727 Cecil Drive; Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Cremation | 11-23-2005 | Stevensville, MD 4 □Dogation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** DEVIENTEA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-transit The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYRER TENSION 1 Yes 2 No 3 Probably 4 Onknown Completed TRANSIENT ISCHEUTE 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t director, page 2 s autopsy performed? 2 NO 2 3 No 1 Yes Hospitel or Attending Physician: 24 hours after death. : After this certification of funeral director, it 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death • Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 035506 0 170. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highwy Bushen Hugland 21122 2109 Ritchie 31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 38247 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Nevember 22 Year **Physician** GEORGE G. MERRILL 2005 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** KESWICK MULTI CARE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/03/1909 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Months Days Hours Min. Director 216-42-7386 96 NEW YORK Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show other treumetic event, the Modical Examiner must be notified at 1 Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 700 WEST 40TH ST. 21211 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: þ Specify: 3 Widowed 4 Divorced WHITE neture!" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) $5 \pm$ PSYCHIATRIST **PSYCHIATRIST** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE G. MERRILL PAULINE DRESSER 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE B. MERRILL(SON) 5005 EDMONDSON AVE. BALTO., MD. 21229. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If eny injury or once. IMMANUEL CHURCH 11/29/2005 SPARKS/GLENCOE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JENKINS & SONS CO. K RD MONKTON, MD. 21111. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart failure Chrome Pnysician congestine /Medical **Examiner** Years Hypertenspe cardinacular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 🗆 No 1 ☐ Yes 1 Yes of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 1 No 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Matural a after oc. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) In palele Vac 013657 grean MO Natrable 22 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOCGREGOR, TOOW YOYL STREET, BALTIMORE, 170 21211 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 2 9 2005

| | | | 1 - For State Registrar | Sta | te of Ma | ryland | / Depa | artment <i>rtificate</i> | of H | ealth a Death | ind M | lental H | ygien Reg. N | | 3 | 8248 |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------|----------------------------------------|----------------------------------------|------------------------|---------------------------|--------------------------------------------|----------------------|----------------------------|------------------------|--------------------------------|------------------|---------------------------|---------|----------------------------------------------------|
| | Physici | ań. | Decedent's Name (First, Midd | lle, Last) | | | | | | | | 2. Date of D | | ay Yea | , | 3. Time of Death |
| | /Medic | | | Mar | y Elizal | beth | Moor | е | | | | | | r 22, 2005 | | 7:20 a.m. ^M |
| F | Examir | | 4a. Facility Name (If not institution | on, give street a | nd number) | | | 4b. City, T | own, or | Location of | f Death | | | c. County of De | | |
| | | | | 422 La | fayette Av | /e | | | | | Cato | nsville | | В | altin | nore |
| à. | Funeral | | 5. Social Security Number | 6. Sex | 7. Age | (In yrs. las | t birthday) | If Under 1 Months | Year Days | If Under 2 Hours | Min. | 8. Date of B (Month, L | irth Day Year | | | ice (State or Foreign |
| | ▽ Director | | 216-16-4653 | 1□M 2 | AF | 83 | Yrs. | | Jayo | 1,00.0 | | | | | | |
| | pu * | | Usual Residence of Decedent 10a. State 10b. Count | , | | 100 City | Town or Lo | | | | | May 21 | 1, 192. | | | aryland |
| | laryla aho | 7 | 102. 0.0.0 | , | | roo. Ony, | TOWIT OF LO | Cation | | | | | | | 10 | d. Inside City Limits |
| | Ne N | Director | Maryland | Baltimore | | | | | | tonsville | = | | | | | 1 ☐ Yes 2 No |
| | with or a | | 10e. Street and Number | | | | | 10f. Zip C | ode | | | | 10g. C | itizen of Whal | Count | y? |
| | within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow ta Madical Exami an rivel be collified at | Completed by Funeral | 422 LaFayette Ave | 1.0.14 | 2 1 . 5 | | | | | 2122 | | | | | .S.A | |
| | er de item | nu | 11. Marital Status | Arm | s Decedent Ev red Forces? | | | Nas Decede f Yes, specif | nt of His y Cubar | spanic Orig n, Mexican, | in? (Spe , Puerto l | ecify Yes or N Rican, etc.) | lo- | 14. Race - Ai Black, W | | |
| 36 | rs aft | y F | 1 Never Married 2 Mai | |]Yes 2% No es, Give ar or Dates: |) | | I ☐ Yes 2 | No | Specify: | | | | Specify: | 1.4 | 0-14 - |
| 5-0036 | hour | pa | | nt's Education | ir or Dates: | | 16a Dagge | lont's Havel | 000000 | tion | | | 100 | (C) - 1 - 1 B | | /hite |
| 5 | in 72 | ojet | (Specify only highe | st grade compi | | | (Give | lent's Usual kind of work DO NOT use | done di | urina most | of worki | ng | 160.1 | Kind of Busine: | ss/Indu | stry |
| 212 | with ene. ther | шc | Elementary/Secondary (0-12) | Coll | lege (1-4or 5+) |) | | | | | | | | E | Bake | У |
| 0 | be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or items 23s or 28s-f ahow avant, tra Medical Examirar mer met be recified at | Ö | 17. Father's Name (First, Middle | Last) | | | | | | nager 18. Mother | 's Name | (First, Middl | e. Maide | n Sumame) | | |
| and | | To Be | \A(:e-) | d Hanni Di | 44! | | | | İ | | | | | | | |
| Mary | should by nd Menta marked imatic av | - | 19a. Informant's Name/Relation | d Henry Bio ship <i>(Type, Prin</i> | | | 19b. Mailin | a Address (| Street a | nd Number | r or Rura | | | Rickman or Town, State | Zin C | onda) |
| Š | 2 4 - 0 | | | | | | | | | | | | | | , 21p C | .000) |
| ā, | s 1 and f Health item 27 other tr | | Mrs. Annamae St 20a. Method of Disposition | uples | Daughte | 20b. Plac | e of Dispo | sition (Name | of | | | lle, Maryl | | 1228 -ocation - City | or Tow | n State |
| <u></u> | 00 | | 15 Burial 2 Cremation | 3 Removal | from State | cem | etery, cren | natory or oth | er piace | 9) | | | | | | |
| altimore, | permit. Page Department Important: If any injury of once. | | 4 □ Donation 5 □ Other (3 | | 1 | G | ood Sh | epherd (| eme | tery | | 8/2005 | | Ellicott C | ity, N | faryland |
| B | Dep fmp eny | | Municipal | / | 101 | AAIM | 2 | | | uneral H | | ВΛ | | | | |
| | (Lower Wall | | 23a. Pay 1. Enter the disease, o | condications | that caused th | no dooth | Do not ont | 387 | 1 Ok | d Colum | ibine, ibja P | ike Ellico | tt City | , MD 2104 | 3 | |
| | | | SPOCK, or neart failure. Lis | only one cause | e on each line. | | / | 7 | | | |) | arrest, | | l li | Approximate Interval Between Onset and Death |
| ~ | Physician | | Immediate Cause (Final disease or condition regulting in death) | _ a | Allur | e t | 0/1 | brier | 10 | with | 2 | USph | Map. | ia | | moot and boath |
| | /Medical Examiner | | Topolity in doziny | D | ue to (or as a | consequer | | | | | | | | | | |
| | | _ | Sequentially list conditions, if any, leading to immediate | b. as | ue to (or as a | ach | 0410 | ر | | | | | | | 1 | 40 |
| 100 | ed isit | line | cause. Enter Underlying Cause (Disease or injury | ₹ | ue to (or as a | consequer | 1 / | 10.0 | 2 (| 2 - : 1 | 1 | 4 | H | | | |
| _ | icate be executed physicien and s the burial-transit | Examiner | that initiated events resulting in death) Last | c. D | ue to (or as a | CONSOCUE | VETSCO | ow | ac | CIR | lux | + wi | 100 | | - | 45 |
| 2 | be e icien buria | | | 1 | 1 1 1 | , | deri | LAKI | No | 210 | | | | | | |
| 08/60 | phys phys s the | edicai | | d. 10 | 1071 46 | por | | 0,0 | Cu | u | | | | · | | |
| _ | eath certifi attending for use as | | IF FEMALE: | 23c If ye | es, outcome of | prognance | | | | | | | | | | |
| ô | death of atten | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 1 🗆 | Live birth 2 | Fetal de | ath 3 | Ectopic preg | | | | | | 23d. Date of d Month | | ay Year |
| o. | the d | ysic | 1 ☐ Yes 2 No 9 ☐ Unknown | | Pregnant at tir Unknown | me or deat | n 5L | Other (spec | rfy) | | | | | | | |
| 7 | ires that the de signed by the a f be detached f | | Part II. Dther significant conditi | ons contribution | a to death but | not regulting | ng in the un | doshina equ | 20 2112 | o in Dart I | | 220 Did | tobooo | | 1- 4 | cause of death? |
| ďŠ, | requires een sign | j by | asternom | 0/5 | Arth | n A | - / | 1/10 | 30 givei | Line | 2 | | | | | ly 4 Unknown |
| ecords | w requir been si should | etec | 00/70000 | | - | 2// | 3,0 | 100 | , w | 7.20 | | - | 105 2 | - CE 140 3 1 1 | TODAL | TOTIK TOWN |
| 9 | S S | Completed | COLITIS WITTE | COLO | Stom | y E | RES | 14510 | n | | | 24a. Was | psy | 24b. Were a | autops | y findings available letion of cause of |
| = | ate pag | S | Immobility | Sun | drom | 6. | Spil | VAI; | FUS | ion | | perf | ormed? | death? | , | D No |
| VII | ysician: Th is certificate director, pag | Be | 25. Was case referred to me ica examiner? | | | | | / | | | of Death | (Check only | one) | | | |
| 6 | d is V | 2 | 1 ☐ Yes 2 No | Hospital: | 1 Inpatient | | /Outpatien | 3□ DOA | Other | 4 Nurs | sing Hom | ne 5 Res | idence | 6 □Other (Sp | ecify) | |
| | ding Ph h. After th funeral | Certification: | 27. Manner of Death 1 ↑ Natural 5 □ Pendii | 28a. | Date of Injury (Month, Day Y | (ear) 28 | 3b. Time of Injury | 280 | . Injury : | at ? | 2 | 8d. Describe | how inju | ry occurred | | |
| UNISION | Vitandi death. ctor: A y the fu | cati | 2 ☐ Accident invest | gation | | | | М | 1 🗆 Y | es 2 N | 0 | | | | | |
| ≥ | | ŧΙ | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | ningd 200. | Place of Injury building, etc. | - At home (Specify) | , farm, stre | et, factory, o | office | | 2 | 8f. Location City or To | Street ar | nd Number or I | Rural F | loute Number, |
| ב | ret D | | | | | | | | | | | | | | | |
| | To the Hospitel or Attand within 24 hours effer death To tha Funerel Director: completely filled in by the f | edicai | (Check only 2] Medical | Examiner: On | the basis of ex | xamination | idga, death and/or inv | occurred at estigation, in | my oni | date and nion, death | place, a | nd dua to the | date an |) and manner a | s state | id. |
| | To the within 2. To the complet | Med | | and | manner state | d. | | | | | | | | | | |
| | To wit | - | 29b. Signature and title of certifie | 0. | 111. | nn | 7 | A | | number | 116 | 2 | | ite signed (Moi | | |
| | | / | Millen | Menl | illy. | 11/1 | | | 5 | 4/ | 49 | | 11 | 23 | 2 | 2005 |
| 6 | 1 | | 30. Name and address of person | who completed | d cause of dear | th (Item 23 | Ba) Type, F | Print) | | | , 1 | + | 0 | 11. | | 4. 4 |
| - | V | | AllEN KEILL | 1. mo. | 45A | 51 1 | 16/11 | oly CI | 055 | Roux | 1 7 | 307 | Bal | Honord | 9/ | 2005 MO 2,228 |
| | Sta | | 31. Date filed (Month, Day, Year) | 07- | 32 moistrar's | s Signature | 9 | | • | | | 1 | | | | |
| | Registr | ar - | NOV 2. 9 | 2005 | F18-0- | H | Box | West | | | | | | | | |

| | | | 1 - For State Registrar | State of | Maryland | | artmen | | | | lental Hy | giene Reg. No. |) 5 | 38249 |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------|-----------------------------------------------|-----------------------------|--------------------------|-------------------------------------------------|----------------------|----------------------------|-------------|----------------------------------|-------------------|----------------------------------------|----------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle | | | | | | | | 2. Date of Dea | ath Day | Year | 3. Time of Death |
| | /Medi | | ALBERT CLIF | | ONALD |) | | | | | NOV | 22 | 2005 | 2:44 PM |
| 4 | Examir | ner | 4a. Facility Name (If not institution Baltimore VA | | cente | V | 4b. City, Town, or Location of Death Baltimore | | | | 4c. Cour | ity of Death | | |
| | Eveneral | | 5. Social Security Number | | . Age (In yrs. la | |) If Under |)61 1 1 Year | If Under | | 8 Date of Birt | h | | ore City |
| | Funeral Director | | 219-28-1702 | 6. Sex 1 M 2 □ F | 72 | | Months | Days | Hours | Min. | 8. Date of Birt (Month, Da | | Coun | lace (State or Foreign try) |
| | P . | | Usual Residence of Decedent | | | | 1 | | | | February 1 | 12, 1933 | 1 1 | Varyland |
| | aryiar show | - | 10a. State 10b. County | | 10c. City, | Town or L | ocation | | | | | | 11 | 0d. Inside City Limits |
| | he M | Director | Maryland | Howard | | | 124 7 | | icott Ci | ty | | | | 1 □ Yes 2 No |
| | d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It amarked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at | | 10e. Street and Number | | | | 10f. Zip | Code | 210 | 142 | 44 | 10g. Citizen o | | • |
| | na 23 | Funerai | 2529 Melba Rd. | 12. Was Deced | lent Ever in U.S | . 13. | Was Deced | ent of Hi | | | acify Yes or No- | 14 R | U.S. | |
| ယ | or iter | F | 1 ☐ Never Married 2 Marr | ied 1 Yes 2 If Yes, Give | es? | | | . / | | , Puerto | ecify Yes or No- Rican, etc.) | В | ack, White, | |
| 03 | ours a | 1 by | 3 Widowed 4 Divorced | If Yes, Give Year or Dat | 19 es: 19 | | 1 ☐ Yes 2 | No No | Specify: | | | Spec | ify: | White |
| 5-0 | 72 h | Completed by | | t's Education st grade completed) | | 16a. Dece (Give | edent's Usua kind of wor DO NOT us | l Occupa k done d | ition <i>uring m</i> os | t of work | ing | 16b. Kind of | Business/Ind | ustry |
| 121 | within ne. than | mpi | Elementary/Secondary (0-12) | College (1- | 4or 5+) | life. | DO NOT us | | | | | 01- | | |
| 2 | filed v Hygie other t | | 17. Father's Name (First, Middle, | (ast) | | | | Chror | ne Plat | 9 | (First, Middle, | Chroy Maidan Sum | ne_ | |
| an | Mental Merked o | To Be | | rl McDonald | | | | | TO. WIOLITE | a a realine | | nie McKe | | |
| Maryland 21215-0036 | 2 should and Menia marker | ř | 19a. Informant's Name/Relations | | | 19b. Mail | ing Address | (Street a | nd Numbe | er or Rum | Al Route Numbe | | | Code) |
| | alth a 27 ta | | Mrs. Jearlene McD | onald M | /ife | | | | | | , Maryland | - | ,,, | |
| re, | Pages 1 arnent of Hearn of Hearn of Hearn of Item | | 20a. Method of Disposition | | 20b. Pla | ce of Disp | osition (Nam | e of | | | ate | 20c. Location | - City or Tox | wn, State |
| E | | | 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | late | - | n Memo | | · | 11/: | 28/2005 | Mari | riottsville. | , Maryland |
| Baltimore, | permit. Pag Department Important: i any injury c | | 21. Signature of Funeral Service | Lio nisee | | | 2. Name and | | | | _ | | | , |
| 8 | Perm Imp | | Mollocup | Mutsu | ent | | 38 | 371 O | uneral | mhia-l | Pike Ellicot | City MD | 21042 | |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that ca only one cause on ea | used the death. ch line. | Do not en | ter the mode | of dying | , such as | cardiac o | or respiratory an | rest, | | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Final disease or condition | Blad | der ca | nce | r | | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (o | r as a conseque | ence of): | | | | | | | | |
| 8 | ZX | | Sequentially list conditions, | b. Due to le | r as a consume | man offi | | | | | | | | |
| | pet lisit | Examiner | cause. Enter Underlying Cause (Disease or injury | Due to to | as a conseque | ятся еще | | | | | | | | |
| | al-tra | xar | that initiated events resulting in death) Last | c Due to (o | r as a conseque | ince of): | | | | | | | | |
| 8760 | ate be executed hysician and the burial-transit | dicai l | | d | | | | | | | | | | |
| 9 | death certificate be executed e attending physician and nd for use as the burial-transit | ledi | , , , , , , , , , , , , , , , , , , , | | | | | | | | | 1 | | |
| Box | eath certific attending p I for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outco | ome of pregnand | | □Ectopic pre | anancy | | | | 23d. D | ate of deliver | у |
| | ie dea the att | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | | nt at time of dea | th 5[| Other (spe | | | | | N | lonth [| Day Year |
| P.0 | that the deed by the detached | Phy | 9 Unknown | | | | | | | | 1 | | | |
| S, | es be | by | Part II. Other significant condition | ons contributing to dea | th but not result | ing in the u | inderlying ca | iuse give | n in Part I. | | | | | e cause of death? |
| Ö | w requir been s should | eted | | | | | | | | | 1 1 | es 2□No | 3 ☐ Proba | ibly 4 Unknown |
| Records, | elaw hast | ompleted | | | | | | | | | 24a. Was a autops | Sy | . Were autop prior to com death? | sy findings available pletion of cause of |
| a | | O | | | | | | | | | | 2 No | | 2 □ No |
| Vital | Phyaicien: 1 this certifical ral director, p | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Managaria (| | 210 | | Othe | | | (Check only or | - | | |
| of | | H- 1 | 1 ☐ Yes 2 No 27. Manner of Death | 28a. Date of | Injury 2 | R/Outpatie 8b. Time o | | Bc. Injury | at | | ne 5 Reside | | | |
| O | nding f th. :: After e funer | tion | 1 Natural 5 Pendin 2 Accident investig | g (Month, | Day Year) | Injury | М | Work' | ? es 2.⊟1 | | | ,, | | |
| Division | i or Attending after death. Director: Afte in by the fune | ifica | 3 ☐ Suicide 6 ☐ Could i | ined 286. Place o | f Injury - At hom | e, farm, st | reet, factory, | office | | - 1 | 28f. Location (S. | treet and Num | ber or Rural | Route Number, |
| ā | tal or A s after al Direc ed in by | Certification: | 4 Nomicide | bunding | , etc. (Specify) | | | | | | City or Tow | п, Згате) | | |
| | To the Hospital or At within 24 hours after or the Funeral Directompletely filled in by | | 29a. Certifier 1 Certifyin (Check only 2 Medical | g Physician: To the b Examiner: On the bas | est of my knowl | edge, deat | h occurred a | it the time | e, date and | d place, a | and due to the c | ause(s) and m | anner as sta | ited. |
| | To the H within 24 To the F complete | Medical | Uney . | and manne | r stated. | 0.10/01 111 | | | | | | | | |
| | To To | | 29b. Signature and title of certified | A | 200/ 44 | 0 | | P 10 | number 165 | 7 | | 9d. Date sign | | |
| • | 1/2 | | Guscinal E | | | | | 1 1 | 140 | 1 | | NOV. 2 | 0,00 | |
| 1 | 1 | | 30. Name and address of person Susannah Batko- | Yourno, M. | 0. 22 : | South | 1 Gre | | Sme | eet, | Baltimo | ore, M | D 212 | 201 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 9 2005 | rar's Signatu | K | field | 0 | | | | | | |

| | | | 1 - For Amend Item#20 Registrar | State of Mary b per FH G84 | land / Depa 9 11/29/ | artment of Hea dificate of De | alth and Me eath | ntal Hygier | 005 | 38250 |
|------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|---------------------------------------------|-----------------------------------------------------|
| | Physici /Medi | | 1. Decedent's Name (First, Middle, La. Michael Mye | rs | | | | Date of Death Month Z | year Year | 3. Time of Death |
| | Examir | | 4a. Facility Name (If not institution, give St PRICS | street and number) | | 4b. City, Town, or Lo | cation of Death | 4 | c. County of Deat | A |
| | Funeral Director | | 5. Social Security Number 6. S | | yrs. last birthday) 57 Yrs. | If Under 1 Year If | | Date of Birth (Month, Day, Yea)2 · 15 · (C | 9. Birth Co. | pplace (State or Foreign untry) |
| | show | _ | Usual Residence of Decedent 10a. State 10b. County | 100 | : City, Town or Lo | | | | | 10d. Inside City Limits |
| | ith the Ma or 28e-f s | recto | 10e. Street and Number | | Balti | 10f. Zip Code | | 10a (| Citizen of What Co | 1₽Yes 2□No |
| | death with the Maryland ms 23e or 28e-f show rmust be redified at | rai Di | 4020 Colbour | le Road | | 217 | 229 | , og. c | USA | |
| 980 | ours after rei', or ite Evernine | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 | | Was Decedent of Hispa f Yes, specify Cuban, M 1 ☐ Yes 2 ☐ No S | anic Origin? (Speci Mexican, Puerto Ri Specify: | fy Yes or No- can, etc.) | 14. Race - Amei Black, White Specify: | ican Indian, , etc. ACL |
| 21215-0036 | in 72 hours n "naturel", ledical Ext | ietec | 15. Decedent's Ed (Specify only highest gra | de completed) | 16a. Deced (Give life. | dent's Usual Occupation kind of work done during DO NOT use retired) | n ng most of working | 16b. | Kind of Business/I | ndustry |
| | be filed within 72 ho tal Hygiene. d other then "natu event, tre Medical | Completed | Elementary/Secondary (0-12) 12th qrade | College (1-4or 5+) | | Laborer | | | Good V | Nill |
| Maryland | | To Be | 17. Father's Name (First, Middle, Last) AVHUW Myers | 5 | | | | First, Middle, Maide A. Bov | | |
| | S E E | | 19a. Informant's Name/Relationship (EVELUN STEVEN) | Type, Print) SSN/MOTH | | g Address (Street and | ne Rual | ′ | | p Code) 229 |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once. | Î | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | Removal from State | b. Place of Dispo | sition (Name of PRAT of COMPCE) | Dat | 9 20c. | Location - City or T | 4 . |
| Balti | permit. Departm Importe any inju | | 21. Signature of Funeral Service Licer | eee Rans | 27 | Name and Address angle C. 151 Baltim | | | | |
| | Physician /Medical | | 23a. Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | al Hovoscl | entic | | uch as cardiac or r | espiratory arrest, | | Approximate Interval Between Onset and Death Velus |
| L | Examiner | | | Due to (or as a cor | | | | | | |
| V | outed id ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a cor | ізациаліся обу, | | | | | |
| 68760, | tificate be executed ig physician and as the burial-transit | edicai Exa | resulting in death) Last | Due to (or as a con | sequence of): | | | | | |
| | entificat ling phy ie as th | - | IF FEMALE: | 20-14 | | | | | | |
| P.O. Box | The law requires that the death certif tte has been signed by the attending page 2 should be detached for use as | Physician/N | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown | Fetal death 3 ☐ | Ectopic pregnancy Other (specify) | | | 23d. Date of deliv Month | ery Day Year |
| Records, P | w requires that s been signed b should be deta | ed by P | Part II. Other significant conditions of Neurofibro (| | t resulting in the ur | nderlying cause given in | n Part I. | 23e. Did tobacco | | the cause of death? |
| al Reco | | Completed by | | | | | | 24a. Was an autopsy performed? 1 ☐ Yes 2 X N | prior to co | opsy findings available impletion of cause of |
| Vital | Physicien: this certific ral director, | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | 2 A R/Outpatien | Other | 6. Place of Death (C | 5 Residence | 6 Other (Speci | 6.1 |
| on of | ₫ = @ | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Yea | | 28c. Injury at Work? | 280 | f. Describe how inju | | 9/ |
| Division | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined | | At home, farm, streecify) | | 2 No | Location (Street a City or Town, Stat | and Number or Rur te) | al Route Number, |
| _ | To the Hospitel or Attenwithin 24 hours after deating the Funerel Director: completely filled in by the | Medicai C | 29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam | /sician: To the best of my iner: On the basis of exam and manner stated. | knowledge, death nination and/or inv | occurred at the time, or restigation, in my opinion | date and place, and on, death occurred | I due to the cause(at the time, date ar | s) and manner as s nd place, and due t | stated. o the cause(s) |
| | To the within To the | Me | 29b. Signature and title of certifier | 1. | | 29c. License nu | | 29d. D | ate signed (Month, | Day, Year) |
| | _ | | 1/2000 1/4 | 2 | // 05 \ T | 7355 | 43 | NOU | encher 2 | 4,2005 |
| _ | 2 | | 30. Name and address of person who keeps H. Scand | completed cause of death | U Cartin | Avenuo | Bulton | ive Ma | my lunch | 4,2005 |
| | Sta Registr | | 31. Date filed (NOV) 2. Yg²/200 | 5 2. Registrar's S | ignature | de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de la company de | | , | / | 1 |

Nyers Michael

| | | | 1 - For State Registrar | State of Maryland / D | epartme C <i>ertifica</i> | | | | 2°005 | 38251 | | | | |
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| | . Dhanisi | | 1. Decedent's Name (First, Middle, Last | | 2. Date of Death Month | | 3. Time of Death | | | | | | | |
| | Physici /Medio | | TOAnne Mc Cryire | | | | | | 24, 2005 | 1.0 | | | | |
| ę | Examin | | 4a. Facility Name (If not institution, give | | 4b. Ci | ty, Town, or | Location of Death | | 4c. County of De | eath | | | | |
| 20 | + | | Carroll Hospital | | | Vestmi | | | Carroll | | | | | |
| | Funeral | | 5. Social Security Number 6. Se | THE OFFICE | nday) If Uni Month | der 1 Year Is Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Y March 27 | (ear) 9. E | Birthplace (State or Foreign Country) | | | | |
| | Director | | Usual Residence of Decedent | 72 Y | 13. | | | March 2/ | ,1933 | PA | | | | |
| | yland | | 10a. State 10b. County | 10c. City, Town | or Location | | | | 10d. Inside City Limit: | | | | | |
| | Man 1 ah | tor | MD Carroll | Fir | | | 1 ☐ Yes 2 🏋 No | | | | | | | |
| | h the | Director | 10e. Street and Number | | | Zip Code | | . Citizen of What | Citizen of What Country? | | | | | |
| | th wil | | 2309 Pheasant Ru | n Drive | | 210 | 48 | | USA | | | | | |
| | ems ems | Funeral | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was De | edent of His | panic Origin? (Spe , Mexican, Puerto | ecity Yes or No- | 14. Race - Ar | nerican Indian, | | | | |
| 36 | or It | y Fu | 1 Never Married 2 Married | 1 ☐ Yes 2 ☒ No If Yes, Give | | 2 X No | Specify: | rican, etc.) | Black, Wi | hite, etc. | | | | |
| 8 | hours ural', | d by | 3 Widowed 4 Divorced | Year or Dates: | | | | | Specify: | White | | | | |
| 21215-0036 | within 72 hours after death with the Maryland one. than "natural, or Items 23s or 28e-1 ahow than "natural, or Items 21s or 28e-1 ahow the Maryland Examination as the rectified at | Completed | 15. Decedent's Edu (Specify only highest grad | cation 16a. I e completed) (| Decedent's U | vork done du | tion <i>uring m</i> ost of worki | ng 16 | b. Kind of Busines | ss/Industry | | | | |
| 7 | withii ene. than | шc | Elementary/Secondary (0-12) | College (1-4or 5+) | Homema | | | | 0 | Home | | | | |
| 0 | filed Hygid othar ant, II | To Be Co | 17. Father's Name (First, Middle, Last) | | пошещ | | 18. Mother's Name | (First, Middle, Ma | | nome | | | | |
| lan | ild be lentai kad ic av | | Carl Gombieski | | Klaczkiewicz | | | | | | | | | |
| Maryland | Should be filed with and Mentai Hygiene is markad othar than aumatic avant, Ine h | | 19a. Informant's Name/Relationship (Ty | pe, Print) 19b. I | Mailing Addre | | | | | , Zip Code) | | | | |
| Σ | permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trae | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. McGuire Husband 2309 Pheasant Run Drive, Finksburg, MD 21048 | | | | | | | | | | | |
| ore | es 1 and Mender of He | | 20a. Method of Disposition | 20b. Place of D | Disposition / | ame of | 1 D | - | c. Location - City of | | | | | |
| Ĕ | mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan tertiment of Health and Mental Hygiene. ordent: If item 27 is marked othar than "natural", or Items 23s or 28e-1 ahow ordent: If item 27 is marked othar than "injury or othar traumatic avant, Ite Marical Examinations and the milled at a. | | 1 \times Burial 2 \to Cremation 3 \to Removal from State \\ '4 \times Donation 5 \times Other (Specify) \\ A11 Saints \text{ Cemetery } \\ 11/28/05 \text{ Reisterstown, MD} \\ 21. Signature of Funeral Service/Licensee \\ \text{22. Name and Address of Facility} \\ \text{11824 Reisterstown Road} \\ \text{128.05} \\ \text{11824 Reisterstown Road} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} \\ \text{128.05} | | | | | | | | | | | |
| Baltimore, | permit. Departi Import any inj | | | | | | | | | | | | | |
| ш | 40 E 29 | | Eline Funeral Home Reisterstown, MD 21136 | | | | | | | | | | | |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between | | | | | | | | | | | |
| | | | Onset and Death | | | | | | | | | | | |
| | | 2 | Intrindicate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of Disease of Conditions) Sequentially list conditions, b. Due to (or as a consequence of Disease of Conditions) | | | | | | | | | | | |
| 6 | | 14 | | Due to (or as a consequence of | Ph | fur | pinor | | | 3 2475 | | | | |
| J | ted nsit | nine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence or, | 11 | | | | | | | | | |
| | al-tra | Examiner | that initiated events resulting in death) Last | Due to (or as a consequence of) |): | | | | | | | | | |
| 68760, | tificate be executed g physician and as the burial-transit | edical | L. | | | | | | | | | | | |
| | tificat ig ph) as th | | | | | | | | | | | | | |
| Box | attending for use | an/N | Zob. Was decedent program | 3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death | 3 □Ectopic | prognanov | | | 23d. Date of de | elivery | | | | |
| Э. | e dea he att | Completed by Physician/M | in the past 12 months? 1 Yes 2 No | 4 Pregnant at time of death | | Month Day Year | | | | | | | | |
| Vital Records, P.O. | at the | | 9 Unknown | | | - | | | | | | | | |
| | w requires that the de been signed by the should be detached | | Part II. Other significant conditions con | tributing to death but not resulting in t | in Part I. | | to use contribute to the cause of death? | | | | | | | |
| | requi | | - (OPD) | | | | | 1 Yes | 2 □ No 3 □ F | Probably 4 Unknown | | | | |
| 3ec | | | | | | | | 24a. Was an autopsy | 24b. Were a | autopsy findings available completion of cause of | | | | |
| <u>e</u> | n: Th icate r. pag | | | | | | | performed | death? | | | | | |
| Division of Vita | siciar certif recto | Be | 25. Was case referred to medical examiner? | ospital: | _ | Other | 26. Place of Death | | | | | | | |
| | Physician: The la r this certificate has ral director, page 2 | To I | 1 Yes 2 10 | 28a. Date of Injury 28b. Tim | | JOA | 4 LI Nursing Hom | e 5 🗌 Residence Bd. Describe how i | | ecify) | | | | |
| | ttanding Phy death. :tor: After thi the funeral o | tior | 1 Natural 5 Pending 2 Accident investigation | (Month, Day Year) Inju | | 28c. Injury a Work? | s 2 □No | DG. Describe now i | njury occumed | | | | | |
| N S | f or Attandil after death. Diractor: A I in by the fu | ifica | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Boute Number | | | | | | | | | | | |
| 2 | al or At s after d al Diract ad in by | Certification: | building, etc. (Specify) | | | | | | | | | | | |
| | | | 29a. Certifier (Check only 2 Medical Examin | icien: To the best of my knowledge, o | leath occurre | d at the time, | date and place, a | nd due to the cause | e(s) and manner a | s stated. | | | | |
| | tha H nin 24 tha F nplete | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(in an another investigation). | | | | | | | | | | | |
| | To Too | | 29b. Signature and title of certifier Varues Pulp 29c. License number D 2 3 443 | | | | | | 29d. Date signed (Month, Day, Ye | | | | | |
| Desgrip | | | | | | | | | 11-24-05 | | | | | |
| | 10 | | 30. Name and address of person who co | mpleted cause of death (Item 23a) (Ty | rpe, Print) 1341 H | more | 131Va | wes | fminst | er.MD21157 | | | | |
| | Stat Registra | MC1/ 0 0 000 = 1 | | | | | | | | | | | | |
| | | | 9 4 4 | THE PROPERTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH | All the same of the | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | | | | | | |

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| | | 1- State of Maryland / Department of Health and Mental Hy Certificate of Death | | | | | | | | | 7005 38252 | | | | | | | |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------|---------------------------|--------------------------|----------------------------------|-----------------------------------|-------------------|-----------------------------------|--------------------------------|--------------------------------------|----------------------------------------------------------------------|-------------------------------------|------------------------|--|--|
| | 0 | | Decedent's Name (First, Middle, Last) | | | | | | | 2. Date of | | | | | neg. No. | | | |
| п | Physici /Medio | | BARBARA | | | | | NA- | ZE | LRO | OD | Month NOVEMBER | Day | 7 Y | ear | 0100 AM | | |
| | Examir | | 4a. Facility Name (If not institution | on, give s | street and nu | ımber) | | 4b. City, | Town, or | Location of | | | | County of | | | | |
| Н | | | THE JOHNS HOPKINS | | | | | BALT | IMO | RE C | ITY | | } | | | | | |
| | Funeral | | 5. Social Security Number UNV | | | | s. last birthday) | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir | rth | 9 | 9. Birthp | lace (State or Foreign | | |
| ь | Director | | | 1 | M XXF | 6. | 5 Yrs. | Moriais | Days | riours | IVINI. | 4-21 | -40 | | MD Cour | nuy) | | |
| | and * | by Funeral Director | Usual Residence of Decedent 10a. State 10b. Count | , | | 10c. 0 | City, Town or Lo | cation | | | | | | | 1 | Od. Inside City Limits | | |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Armordant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Modreal Examitise in sail by notified at once. | | MD | | | В | altimo | re | | | | | | | | Yes 2 □ No | | |
| | | | 10e, Street and Number | | | | | 10f. Zip Code | | | | | 10a Citi | zen of Wh | 21 Caus | | | |
| | 3a or | Ö | 105 S. Washi | ngto | on St | reet | | | 231 | | | | | S.A. | | ury? | | |
| | death ms 2 | era | 11. Marital Status | | | edent Ever in | U.S. 13. | Was Deced | lent of Hi | spanic Ori | ain? (Sae | cify Yes or No | | 14. Race - | | an Indian | | |
| 9 | after or Ite | Fur | 1 X Never Married 2 ☐ Mai | rried | Armed F 1 ☐ Yes | 2X No | - 1 | _ | | | | cify Yes or No Rican, etc.) | | Black, | White, | etc. | | |
| 93 | ral', | d by | 3 ☐ Widowed 4 ☐ Divorce | b | If Yes, G Year or [| ve Dates: | | 1□ Yes | EF4N0 | Specify: | | | | Specify: | Wh: | lte | | |
| 21215-0036 | 72 h 'natu | Completed | 15. Deceder (Specify only higher | | |) | 16a. Dece | kind of wor | k done d | lurina mosi | t of workir | na . | 16b. Kir | nd of Busin | ness/ind | dustry | | |
| 121 | vithin ne. han | mpi | Elementary/Secondary (0-12) | Ť | College (| (1-4or 5+) | life. | DO NOT us | e retired, |) | | .9 | _ | | | | | |
| 20 | Hygie Hygie Ther t | | 9th 17. Father's Name (First, Middle, | (act) | | | Ser | ver | | 10 Mash | d- N | /C 48.18 | | taur | ant | | | |
| Maryland | il be fi | To Be | Harry Melvin | Naz | Nazolrod | | | 18. Mother's Nam Swerit: | | | | | | den Surmarme) Le Arlea | | | | |
| | should d Me mark matic | | 19a. Informant's Name/Relations | shin /Tvr | sip (Type, Print) 19b, Maili | | | a Addross | /Street o | | | | | ate, Zip Code) | | | | |
| | od 2 stranger tranger | | Theresa Mice | | , , , , , , , , | | 105 | S. Wa | ashi | nato | on S | t. Ba] | ltim | ore | атө, <i>∠лр</i> М Г\ | 21231 | | |
| ē, | f Healitem | | 20a. Method of Disposition | | | 20b. | Pface of Disno | cition /Nam | an of | | 0 | ata | 00-1- | | | | | |
| altimore, | Pages ent of nt: If i | | 1 ☐ Burial 2XX remation 1 ☐ Donation 5 ☐ Other (| 3 □Re Specify) | emoval from | State Ba | cemetery, crentally View | Cren | nato | ry 1 | 1-29 | 9-05 | Dund | alk, | MD | , | | |
| 票 | mit. A partm portan inju | | 21. Signature of Fyneral Service | | | | | | | | | | | | | | | |
| Ö | Depa fmpo any ir | | * allsley | K | eves | D' | 20 | 007 E | East | ern | Ave | . Balt | .0. | MD 2 | 123 | 1 | | |
| | Physician /Medical Examiner | | 23a. Part1. Enter the dismase, o shock, or heart failure. Lis | r complic | cations that | caused the dea | | | | | | | | | | Approximate | | |
| | | | Immediate Cause (Final disease or condition | | | | Onset and | | | | | | | | Interval Between Onset and Death | | | |
| | | | resulting in death) | a | a. RVPTURED GASTRIC ULCER Due to (or as a consequence of): | | | | | | | | | 2 | 4 HOURS | | | |
| | | | Coguantially list conditions | , | METASTATIC LUNG CANCER | | | | | | | | | | | MONTH | | |
| | D == | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | , " | Due to (or as a consequence of): | | | | | | | | | | | | | |
| | and trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last |) c. | c | | | | | | | | | | | | | |
| 8760, | cate be executed physician and the burial-transit | j E | rodaling in double cast | | Due to | (or as a conse | iquence of): | | | | | | | | | | | |
| x 687 | physi the t | dicai | | d. | d | | | | | | | | | | | | | |
| | ding se as | /Me | IF FEMALE: | 23 | C If yes ou | yes, outcome of pregnancy | | | | | | | | | | | | |
| Box | atten for u | cian | in the past 12 months? | | | | | | Ectopic pregnancy Other (specify) | | | | | 3d. Date of Month | y Day Year | | | |
| P. O. | that the death certifued by the attending to detached for use as | Physician/Me | 25. Was case referred to medical examiner? | | | | | | | | | | | | | | | |
| Records, P. | es that igned b | by Pl | | | | | | | | n in Part I. | | 23e. Did to | bacco us | a cause of death? | | | | |
| | The law requires that the death certifin to has been signed by the attending page 2 should be detached for use as | | | | | | | | | 1 🗆 Y | Yes 2 No 3 Probably 4 □Unknown | | | | | | | |
| 000 | aw re | Completed | | | | | | | | | 24a. Was | an | 24b. Were autopsy findings available | | | | | |
| m m | The taw ate has page 2 s | | | | | | | | | | | med? | prior | r to completion of cause of th? | | | | |
| Vita | ysician: This certificate | ВеС | | | | | | | | 26. Place | | | | | | fes 2□ No | | |
| | Physician: this certificaral director, | To | | | | | | | | e 5 Resid | 5 ☐ Residence 6 ☐ Other (Specify) | | | | | | | |
| Division of | | | 27. Manner of Death 1 X Natural 5 ☐ Pendir | 28 | c. Injury Work | | | 8d. Describe how injury occurred | | | | | | | | | | |
| <u>s</u> | Attending or death. ector: After by the fune | cati | 2 Accident investi 3 Suicide 6 Could | gation | | | | М | | es 2 N | 10 | | | | | | | |
| \leq | after death after death Director: , d in by the f | Certification: | 4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) | | | | | | | | | | | ation (Street and Number or Rural Route Number, r or Town, State) | | | | |
| | pital ours a erat [| | | | | | | | | | | | | | | | | |
| | To the Hospital within 24 hours a To the Funerat I completely filled | edicai | 29a. Certifier (Check only one) 29a. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 30a. Medical Examiner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. 30a. Certifier (Check only one) | | | | | | | | ted. the cause(s) | | | | | | | |
| | To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by | Me | 29b. Signature and title of certifie | r | and mail | otalog. | | 29c. | License | number | | | 29d. Date | signed (M | fonth. D | ay, Year) | | |
| | | | 1 Windle | } | M | DIC AL T | DOCTOR | R | RES. | - 000 | > | | | | | 2005 | | |
| - | 1 | - | 30. Name and address of person | who con | | | | ' | | | | | | | 101 | | | |
|) | - | | Robin Veidt THE | | | | | | NW | LFF S | T. BA | LTIMORE | . M | ARYLA | ND | 21287 | | |
| : | Sta | te | 31. Date filed (Month, Day, Year) | | 32 | istrar's Sign | ature | - | | | | | | | | | | |
| | Registra | ar | NOV 2. 9 | 2005 | de | BAR I | S. Sou | ME) | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiefje | | 5

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| | | | 1 - For State Registrar | | State of I | viaryland / | | artment of F <i>rtificate of</i> | | Mental H | ygienelle | 105 | 38253 |
|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------|---------------------------------------|----------------------|----------------------------------------------|-----------------------------------------------------|-----------------------------------|-------------------------------|-------------------------------------------|----------------------------------------------------|
| | Dhusia | | 1. Decedent's Name (First, | Middle, Las | st) | | | - International | | 2. Date of D | eath | | 3. Time of Death |
| | Physic /Medi | | ME'RYA | I JANA | AI NOCK | | | | | Nove | mber a | 20, 700 5 | 0916 AM |
| 1 | Exami | | 4a. Facility Name (If not ins | titution, give | street and number | er) | | 4b. City, Town, o | or Location of Death | | | ounty of Death | |
| | | | Sinai Ho | 5 pi- | terl | | | Balt | fmore | | N | I/A | |
| | Funeral Director | | 5. Social Security Number | 6. S | 9X 7. □ M 2 X XF | Age (In yrs. last b | irthday) Yrs. | Months Days 4 16 | If Under 24 Hrs. Hours Min. | | ay, Year) | Coun | lace (State or Foreign try) ZLAND |
| | and | | Usual Residence of Deceded | | | 10c. City, Tox | wn or Lo | | | 10021 | 2003 | | Od. Inside City Limits |
| | with the Maryland a or 28a-f show | 5 | MA DATE AND | | | | | | | | | " | 1 ☑ Yes 2 ☐ No |
| | the 28a | Director | MARYLAND 10e. Street and Number | N/A | | BA | .Т. <u>Т.</u> ТТ | MORE 10f. Zip Code | | | 100 Citizer | n of What Coun | ** |
| | ath with 23a or | O | 3700 GWYN1 | IC FAT | TC DEMV | APT A | | | 1.6 | | | | ay. |
| | e E 5 | Funeral | 11. Marital Status | D IAL | 12. Was Decede | nt Ever in U.S. | 13. | Was Decedent of H | : 10 Hispanic Origin? (Sp an, Mexican, Puerto | pecify Yes or N | o- 14. | .S.A. Race - Americ | an Indian, |
| 5-0036 | or Its | by Fu | XXNever Married 2□ 3□ Widowed 4□ Div | | Armed Force 1 ☐ Yes 2[If Yes, Give Year or Date | XNo | | f Yes, specify Cubi 1 ☐ Yes 2 🛣 No | | Rican, etc.) | 1 | Black, White, e | |
| Š | 72 hours "natural", dical Ex. | ted | 15. De | edent's Ed | ucation | 168 | . Dece | dent's Usual Occup | ation | | | of Business/Ind | |
| 2121 | permit. Pages 1 and 2 should be filed within 72 ho Depuriment of Health and Mental Hygiene. Important: if item 27 la marked other than "natur any njury or other traumatic event, II a Medical once. | Completed | Elementary/Secondary (C | | de completed) College (1-4c | or 5+) | irfe. I | DO NOT use retired | during most of work | king | | | |
| | filed Hygi other ent, I | CO | 17. Father's Name (First, M | ddle, Last) | | | N/A | 4 | 18. Mother's Nam | e (First Middle | N/ | | |
| <u>a</u> | Mental Mental arked c | To B | MARVIN | NOCK | | | | | | YA BARB | | mame) | |
| Maryland | 2 shou and M la mar aumat | - | 19a. Informant's Name/Rei | | ype, Print) | 19 | b. Mailir | g Address (Street | and Number or Rui | | | own, State, Zip | Code) |
| _ | and 2 lealth s m 27 Is | | LaToya Barbo | ur/Mo | ther | | | | Falls Fkv | | | | |
| ore. | of He of Herr | 1 1 | 20a. Method of Disposition | | | 20b. Place | of Dispo | sition (Name of natory or other place | | Date | 20c. Locat | ion - City or To | wn, State |
| Ē | Pages nent of ant: If it ary or o | ١., | 1 🖾 Burial 2 □ Crem: `4 □ Donation 5 □ Ott | ition 3 ∐ ier (<i>Specif</i> y | Removal from Sta | 10 | | CEMETERY | | 26-05 | LANSD | OWNE M | ARYLAND |
| Baltimore | permit. Pag Department Important: any injury o | ł . | 21. Signature of Funeral S | vice Licen: | OK_ | | W] | Name and Addre | ss of Facility BROWN COM | MUNITY | | | |
| | - | | 23a, Part 1, Enter the disea | se, or come | lications that caus | ed the death. Do | 12 | 206 W NOR | TH AVENUE | <u> </u> | | | |
| | | | 27a. Fart1. Enter the disea shock, or heart failure Immediate Cause (Final | List only | | | | | | | | | Approximate Interval Between Onset and Death |
| | Pnysician / /Medical | | disease or condition resulting in death) | 1 | allettic | Ulty ce | NTO | rolling or | a/secre | tions | 1410 | way 4 | 1/2 months |
| | Examiner | | | | Due to (or a | as a consequence | or): | 1 | 00.00 | 1.1.0 | - 42. | 1 0 | Onset and Death Mowths Moments Months |
| | | ē | Sequentially list conditions, if any, leading to immediate | J | b. Du lo (or a | as a consequence | of): | remie | ercegn | rasop | arry | - | . I. |
| V | icate be executed physician and s the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 1 | PIA | centa | | Abrupt | 10 | | 31750 | 7 | 12 months |
| 0, | e exe ian ar ırial-t | Ex | resulting in death) Last | - 8 | Due to (or a | as a consequence | of): | / | | | | | |
| 68760, | ate be hysici | ledical | | • | d | | | | | | | | |
| | entific ling p | | IF FEMALE: | | | | | | | | - [| | |
| .O. Box | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit | Physician/A | 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | nt | | 2 Fetal death at time of death | | Ectopic pregnancy Other (specify) | | | 23d. | Date of deliver Month | y Day Year |
| <u>α</u> | s that the ned by a detact | by Ph | Part II. Other significant co | nditions co | ntributing to death | but not resulting i | n the un | derlying cause give | en in Part I. | 23e. Did 1 | obacco use d | contribute to the | cause of death? |
| Records, | w requires been signs should be | | | | | | | | | 1 🗆 | Yes 2□N | o 3∏Proba | bly 4 Unknown |
| Rec | The law cate has b | Completed | | | | | | · | | 24a. Was auto perfo | | 4b. Were autop: prior to com death? | sy findings available pletion of cause of |
| Vital | | a | 25. Was case referred to me | dical | | | | | OC Place of Death | 1 Yes | 212 No | 1 ☐ Yes 2 | 2□ No |
| <u>></u> | Phyaician: this certific ral director, | To B | examiner? 1\ZYes 2 ☐ No | | Hospital: | tient 2 ER/Ou | utpatient | 3□ DOA Othe | 26. Place of Deatler: 4 ☐ Nursing Ho | | | Othor (Specific) | |
| J Of | ding Ph h. After th funeral | | 27. Manner of Death | | 28a. Date of In (Month, D | jury 28b. | Time of | 28c. Injury | at | 28d. Describe | | | |
| <u>Ö</u> | andin ath. or: Af | atlc | 2 Accident in | ending vestigation | (MONN), D | ay row, | Пјигу | M 1 🗆 ' | Yes 2 □No | | | | |
| Division | or Attanding after death. Diractor: After d in by the fune | Certification: | | ould not be etermined | 28e. Place of I | njury - At home, fa etc. (Specify) | ırm, stre | et, factory, office | | 28f. Location (| Street and Nu wn, State) | umber or Rural | Route Number, |
| | oital curs al | | | | | | | | | | | | |
| | To the Hospital within 24 hours a To the Funeral Completely filled | edical | 29a. Certifier 1 Certifier (Check only 2 Medone) | tifying Phy lical Exami | sician: To the bes ner: On the basis and manner s | or examination an | e, death d/or inv | occurred at the time estigation, in my or | e, date and place, pinion, death occurr | and due to the ed at the time, | cause(s) and date and plac | I manner as sta ce, and due to t | ted. he cause(s) |
| | To the To the Comp | ž | 29b. Signature and title of co | rtifier | | - | | 29c. License | number | | 29d. Date sig | gned (Month, D | av Year) |
|) | | | Ovan | m | Tan | to MI | 1 | 031 | 1072 | | 11/2 | 1/05 | |
| | 2 | | 30. Name and address of pe | rson who co | 1 - 1 | death (Item 23a) | (Туре, F | Print) | idal al | C Dal | 1 & ide no | -0 | |
| | | 10 | 31. Date filed (Month, Day, | (ear) | 16 C / | trar's Signature | INC | LI HOSP | ital of | 1901 | Tr WUY | - | |
| | Sta Registr | | • | | 05 | Cars Signature | 1 | BARRY . | | | | | |

| | | | For State Registrar | State of Maryland | | artment of Heali rtificate of Dea | | | еле 0 0 | 5 3 | 88254 |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------|-------------------------------------------------------|------------------------------------|------------------------------------|--------------------------|------------------------------------|--------------------------------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, Las | 1 0 | | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
| | /Medic Examir | | 4a. Facility Name (If not institution, give | 7. — [| | 4b. City, Town, or Local | tion of Death | 11 . | 2/ sc. Sounty | of Death | O.)1 A™ |
| | LAdilli | ici | GENESIS - LONG | 1 | TER | BALTIM | | | | Timo. | e F |
| | Funeral | | 5. Social Security Number 6. S | 7. Age (In yrs. la | st birthday) | | nder 24 Hrs. | 8. Date of Birth (Month, Day, | | | ice (State or Foreign |
| | Director | | 016-18-5053 | M 2□F 8 | Yrs. | Widness Days Floor | urs Willi. | 5/25/ | 1924 | | CHALL |
| | land | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 10 | d. Inside City Limits |
| | Mary F-f sh | ţō | mo | R | ALTIN | 200 F | | | | | 1 ☐Yes 2 ☐ No |
| | th the | Director | 10e. Street and Number | | rici iii | 10f. Zip Code | | 10 | g. Citizen of W | /hat Countr | y? |
| | ath wi | rai | 6127 MACBETT | | | 21239 | 9 | | US | A | |
| | er de: Itams | Funeral | 11. Marital Status | 12. Was Decedent Ever in U.S Armed Forces? | | Was Decedent of Hispanio f Yes, specify Cuban, Me: | c Origin? (Spec xican, Puerto R | ify Yes or No- ican, etc.) | | - America k, White, et | |
| 39 | be filed within 72 hours after death with the Maryland nia! Hygiene. od other than "natural", or itams 23a or 28a-f show event, the Medical Examiner must be notified at | by F | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | 1□Yes 2⊡No Spe | ecity: | | Specify | 1 | TE |
| 21215-0036 | 72 hou | | 15. Decedent's Ed | | | lent's Usual Occupation | | 1 | 6b. Kind of Bu | siness/Indu | 17 E |
| 21 | within 7 ene. then "r | Completed | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5+) | life. L | kind of work done during OO NOT use retired) | | 7 | \cap | 10 | |
| | e filed within al Hygiene. I other than ' | | 17. Father's Name (First, Middle, Last) | | SEL | | | (=: | AINTE | | ARPENTAR |
| and | d be f antal h ced of | o Be | 7 | DOTA | | 18. N | | First, Middle, M | | θ) | |
| Maryland | 2 should be and Mental is marked a aumatic ev | J. | 19a. Informant's Name/Relatio ship (7 | ype, Print) | 19b. Mailin | ig Address (Street and Nu | umber of Rural | | NG-EA City or Town, : | State, Zip C | code) |
| - | 27 m | | END C. ORTH / | SPOUSE | 6127 | MACBETZ | 1 De. | BALTI | MORE | mo | 21239 |
| Baltimore , | permit. Pages 1 ar Department of Hea Important: if item any injury or othe once. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ | | nce of Disponentery, crem | sition (Name of natory or other place) | Nover | te 2 | Og. Socation - | City or Tow | |
| ţ | t. Pag tment tant: njury o | | `4 ☐ Donation 5 ☐ Other (Specify | TAR | Kwood | | 25,2 | 005 | TARK | | MD |
| Bal | permit. Departr Importa any Inji | | 21. Signature Funeral Service Licen | | Ele | Name and Address of F | Res R | O. PAR | KUILLE | | APEC 0 21234 |
| | | | 23a. Part 1. Enter the disease, or composition of heart failure. List only of | nie cause on each mie. | | | | respiratory arres | st, | 1 | Approximate nterval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. META | TATE | 10 PROS | STATE | CAR | いてって | 1A | Onset and Death |
| | /Medical Examiner | | | Due to (or as a conseque | ence of): | | | | | | |
| h, | | ler | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a conseque | ence of): | | | | | | |
| | cuted nd ransit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | |
| 90, | tificate be executed g physicien and as the burial-transit | | resulting in death) Last | Due to (or as a conseque | ence of): | | | | | | |
| 68760, | cate b | edicai | | d | | | | | | | |
| _ | eath certiff attending for use as | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregnance | cy | | | | 22d Date | of delivery | |
| Box | The law requires that the death certifule has been signed by the attending to be 2 should be detached for use a | Physician/M | in the past 12 months? | 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea | | Ectopic pregnancy Other (specify) | | | Mon | | ay Year |
| P.0 | by the | hys | 9 Unknown | 9□ Unknown | | | | | | | |
| | res this igned be de | þ | Part II. Other significant conditions co | ntributing to death but not result | ing in the un | derlying cause given in P | art I. | | | | cause of death? |
| oro: | w require been si should? | eted | | | | | | 1 L Yes | 2 🗆 No | 3 Probab | ly 4 Unknown |
| Vital Records, | has by | Completed | | | | | | 24a. Was an autopsy performe | pr | ere autops for to comp eath? | y findings available letion of cause of |
| <u>a</u> | | e Co | 25. Was case referred to medical | | | | | 1 ☐ Yes 2 | | Yes > | No. |
| | | To Be | examiner? | Hospital: 1 ☐ Inpatient 2 ☐ El | R/Outpatient | 0.4 | , | Check only one) 5 Residen | ce 6 □Othe | (Speciful | |
| 0 | ng Phys ter this neral di | T: uc | 27. Manner of Death | T | 8b. Time of Injury | 28c. Injury at Work? | | d. Describe how | | | |
| Siol | ttendir death. stor: Af | catic | 2 Accident investigation | (,, , , , , , , , , , , , , , , , | ,, | M 1 ☐ Yes 2 | 2 □No | | | | |
| Division of | i Diffic | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At hom building, etc. (Specify) | e, farm, stre | et, factory, office | 28 | f. Location (Stre City or Town, | | r or Rural F | loute Number, |
| _ | ospitei hours a unerei ly filled | | 29a. Certifier 1 Certifying Phy | sician: To the best of my knowl | edge death | occurred at the time, date | e and place, and | d due to the cau | se/s) and man | nor as state | ad. |
| | To the Hospitel within 24 hours a To the Funeral I completely filled | edical | (Check only 2 Medical Exam one) | iner: On the basis of examinatio and manner stated. | n and/or inv | estigation, in my opinion, | death occurred | at the time, date | e and place, ar | nd due to th | e cause(s) |
| | To the within 2 To the complet | Σ | 29b. Signature and title of certifier | 0 0 | M | 29c. License numb | per | 290 | I. Date signed | (Month, Da | |
| į. | 100 | | House | 7-12-66 | | DI | 168 | 0 | 11 | L 3 | 5002 |
| 1 | Y | | 30. Name and address of person who co | oppleted cause of death (Item 2 | (Type, F | tint) Porl | r Ha | - ples | Ave | 2 " | 21215 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Ranstrar's Signatu | re A | and i | | 4 | | | |
| | negistr | all | NOV 2 9 2 | 2005 Seere A | 5 /5 | | | | | | |

| | | | For State Registrar | State of Maryl | | artment of F | | Mental Hy | giene 05 | 38255 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------|-----------------------------------------------------------------|----------------------------------------------------|
| | Physici /Medi | | 1. Decedent's Name (First, Middle, Last LORDAINE (| 2. OCHAB | 3 | | | 2. Date of De Month | | 3. Time of Death 9:30 A M |
| | Examir Funeral | | 4a. Facility Name (If not institution, give SHAS HOPK (WS BAS) 5. Social Security Number 6. S | NIEW MED ex 7. Age (In | CTR yrs. last birthday, | BALTT. | r Location of Death MORC If Under 24 Ars. Hours Min. | MARYLA 8. Date of Bir (Month, Da | 4c. County of Deat ALI th ay, Year) 9. Birt Co | MORE CITY hplace (State or Foreign untry) |
| * | Director | | 215–30–2458 Usual Residence of Decedent 10a. State 10b. County | /1 | Yrs. City, Town or L | | | 2/7/19 | 934 Mar | yland |
| | the Maryla 28a-f shov | Director | Maryland Baltimor | | Essex | | | | 10g Citizen at Minet Co | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| -0036 | be filed within 72 hours after death with the Maryland tal Hygiene. od other then "natural", or Itema 23a or 28a-f show event, tra Madical Exertiral must be rotified at | by Funeral | 923 Essex Square 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Amed Forces? 1 | | 10f. Zip Code 21221 Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No | Specify: | pecify Yes or No o Rican, etc.) | Specify: | ncan Indian, a, atc. |
| Maryland 21215-0036 | d within 72 giene. ir then "ne ine Medic | Completed | (Specify only highest gra Elementary/Secondary (0-12) 12 | | (Give | kind of work done of DO NOT use retired | during most of world | king | Own Home | industry |
| land | thould be filed and Mental Hygid marked other matic event, I | Be | 17. Father's Name (First, Middle, Last) Robert E. | Taylor | | | 18. Mother's Nam | ne (First, Middle Nola | , Maiden Sumame) | |
| Baltimore, Mary | les 1 and 2 sh of Health and of Item 27 is m or other traum | | 19a. Informant's Name/Relationship (1) Walter Ochab, Sr. 20a. Method of Disposition 1 월 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific | (Husband) | 923 b. Place of Disposemetery, cre | ESSEX Squ osition (Name of matory or other place | are Esse | | er, City or Town, State, 2 Land 21221 20c. Location - City or | Town, State |
| Baltir | permit. Pag Department Important: eny injury c | | 21. Signature of Funeral Service Licen | See Sr. | B: | ary Cemeto 2. Namo and Addro ruzdzinsk 407 Old E | ss of Facility i Funeral astern Ay | l Home F zenue F | Issex. Marvl | * |
| 8760, | Physician /Medical Examiner the private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private and private a | icai Examiner | 23a. Part1. Enter the disease, or common shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Lacti Due to (or as a con | isequence of): GRULL sequence of): | dosis Sheek | g, such as cardiac | or respiratory a | rrest, | Approximate Interval Between Onset and Death |
| O. Box 6 | The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit | Physician/Medicai | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown | etal death 3 | □Ectopic pregnancy | , | | 23d. Date of deli Month | very Day Year |
| Δ. | quires that in signed by uld be deta | by | Part II. Other significant conditions o | ontributing to death but not | resulting in the u | inderlying cause giv | en in Part I. | 23e. Did t | obacco use contribute to Yes 2. No 3 ☐ Pro | the cause of death? |
| of Vital Records, | | Completed | | | | | | 24a. Was autop perfo | | topsy findings available ompletion of cause of |
| ion of Vita | Attending Physician: r death. ector: After this certific by the funeral director. | ation: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation | 28a. Date of Injury (Month, Day Yea | 2 ER/Outpatier 28b. Time of Injury | f 28c. Injun Wor | 4 Nursing n | ome 5 Resi | one) dence 6 □Other (Spechow injury occurred | ify) |
| Division | i git e | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - A building, etc. (Sp. | | reet, factory, office | | 28f. Location (S City or Tox | Street and Number or Ru wn, State) | ral Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Direct completely filled in the funeral or the funeral Direct completely filled in the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or th | edicai (| 29a. Certifier (Check only one) 1 Certifying Ph | ysician: To the best of my illier: On the basis of examand manner stated. | knowledge, deat | h occurred at the tin vestigation, in my o | ne, date and place, pinion, death occur | and due to the red at the time, | cause(s) and manner as date and place, and due | stated. to the cause(s) |
|) | To the within 2 To the complete | W | 29b. Signature and title of certifier | | MD | 29c. Licensi | | | 29d. Date signed (<i>Month</i> | |
| | 12 | | 30. Name and address of person who Michael Eberlein, MD | 4940 Easteru | Avenue | Baltimen | 3 - 00/ e MD 21 | 1224 | · | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) NOV 2 9 200 | 52. Registrar's S | ignature | | | | | |

State of Maryland / Department of Health and Mental Hygiene 38256 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Ε. **Physician** Albin Owings 945 PM Newver 13 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Keswick MultiCare Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2–15–1923 **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 1**X**CXM 2□ F Yrs. 82 Director 215-12-2664 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28e-1 show other traumatic event. The Medical Examinar must be notified at N/A Baltimore Maryland 1 X Xes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4226 Elsa Terrace 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Itan 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City, MD 10th Fire Fighter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albin E. Owings Eva Jane Tice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Itam 27 Is any injury or other trau once. Mrs. Betty Owings Wife 4226 Elsa Terrace Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Maryland Veteran XX Burial 2 ☐ Cremation 3 ☐ Removal from State Cem. 12/2/2005 Garrison Forest, MD ^¹ 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. of Funeral Service Lice 3631 Falls Road Baltimore, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician atem 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** rears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Jurising Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After After 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funaral Di 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) barrelle 01365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 th STREET, BALTIMERE, MY 21211 YREGOR LRABELLE TAR 00 W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygie (= For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician Iris Silver Oliver November 27, 2005 3:36 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice @ GBMC Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 KF Director 241-32-0312 89 South Carolina May 6, 1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 le marked other then "naturel", or itame 23a or 28a-1 show or other traumatic event, it e Madical Examinar must be notified at WYes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Hamlet Hill Road 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ۵ 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental James Martin Silver Moseley Lura (mmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any injury or other trau once. 8 Cameray Heights, Laguna Niguel, CA 92677 Patricia E. Oliver / Step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Spesutia Cemetery 11-28-05 4 ☐ Donation 5 ☐ Other (Specify) Perryman, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death -4 week **Physician** erebrovascula /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes rs after deau...
ral Director: After this cer.... To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C who completed cause of death (Item 23a) (Type, Print) endall 6601 N. Charles aulener MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

State Registrar

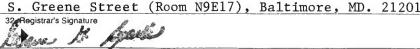
31. Date filed (Month, Day, Year) NOV 2 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22

29b. Signature and title of certifier

7. Oven

Kevin Cullen, M.D.



DHMH 17 Rev 1/2001

MI

29c. License number

D0034714

29d. Date signed (Month, Day, Year)

November 24, 2005

05-8000 B.K.S. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. WILLIAM P. PALO JR. State of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a,27,28a-f per mer Associated 2010 Sathtas Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** William Ρ. Palo NOV. 2005 0736 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESAPEAKE BAY, DOWNS PARK PASADENA ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec 12 Birthplace (State or Foreign Country) **Funeral** Months Hours 1 X M 2 □ F 1955 49 Yrs. 214-72-1288 Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 1847 Poplar Ridge Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc filed within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 12 0wner Sandblasting Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental P Peges 1 and 2 should be Ρ. Slanker William Palo Marilyn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2:
Department of Heelth at Important: If Item 27 is eny injury or other treuonce. Marilyn Palo 1847 Poplar Ridge Road, Pasadena, MD 21122 (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 2005 02 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li Stallings Funeral Home, P.A. 3111 Mountain Ro<u>ad, Pasadena, MD 21122</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode or dyring, such as shock, or heart failure. List only one cause of each one.

Drowning and Hypothermia associated with Alcohol Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transit Due to (or as a consequence of) physicien Physician/Medical . 45 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ဥ

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Director: After this in by the funeral d within 24 hours after death.

To the Funerel Director: A death. ŝ

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) AT SCENE 1XYes 2 No 28b. Time of 27 Manner of Death Pourid (h, Day Year) Subject drowned and was exposed 28c. Injury at Work? 5 Pending investigation Found at 7:26 A 1 Natural 2 Accident to cold environment 1 ☐ Yes 2 ☐ XNo 11-27-05 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number City or Town, State) 8205 Bayside Drive 4 Homicide Water Pasadena, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. NOV. 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Registrar

Certification:

Medicai

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LING

mD 111 PENN STREET, BALTIMORE, MARYLAND 21201 32. Signature

| | | | 1 - For State Registrar | State of Maryla | | irtment of tificate of | | | giene 0 | 5 3 | 8260 | | | |
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| | Physici | | Decedent's Name (First, Middle, Las | - 1 | acki | | | 2. Date of De Month | Day | Year 2005 | 3. Time of Death | | | |
| | /Medic Examir | | 4a. Facility Name (If not institution, give Johns Hopkins L | | 1 Carter | 4b. City, Town, | or Location of De | ath | 4c. County | | | | | |
| | Funeral Director | ů. | 5. Social Security Number 242-01-0107 6. Security Number 242-01-0107 | 7. Age (In yr | s. last birthday) 85 Yrs. | If Under 1 Yea Months Day | | Irs. 8. Date of Birt in. (Month, Da April 18 | y, Year) | Count | ace (State or Foreign try) ginia | | | |
| | r 28a-f show | Director | 10a. State 10b. County Maryland NA 10e. Street and Number | | City, Town or Loc | | | | 10g. Citizen of | | Od. Inside City Limits 1 Yes 2 No X | | | |
| 9600 | be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23e or 28e-1 show event, the Medical Exem har must be notified at | by Funeral | 2526 McElderry 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced | Street 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | 1 | ☐ Yes 2 N | Hispanic Origin? Iban, Mexican, Pu o <i>Specify:</i> | (Specify Yes or No erto Rican, etc.) | 14. Rad Bla Specif | Whi | an Indian, tc. Lte | | | |
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| Maryland 2 | should be filed ind Mental Hygi is marked other umatic event, I | To Be C | 17. Father's Name (First, Middle, Last) UnKno | | | | | lame (First, Middle, Jnknown | | | | | | |
| | 1 and 2 Health a em 27 H | | Joseph Plewacki 20a. Method of Disposition | (Nephew) | 62 Adr | miral B1 | .vd. Dunc | Rural Route Number lalk, Mary Date rember | | 1222 | | | | |
| Baltimore, | it. Page ritment c ritent: if njury or | | M☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licent | 0 | ak Lawn | Name and Add | 30, | 2005 E | | | Maryland | | | |
| B | permi Depa Impo any i | | W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death | | | | | | | | | | | |
| 8760, | Physician /Medical Examiner physician and physician and physician and the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state of the physician state o | dical Examiner | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Brain Due to (or as a conse b. Due to (or as a conse c. Vascu Due to (or as a conse d. | equence of): equence of): | nial. | | | | 2 2 | Days Dyears | | | |
| P.O. Box 6 | The law requires that the death certificate hes been signed by the attending plage 2 should be detached for use as | Physiclan/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown | tal death 3 🗌 | Ectopic pregnan Other (specify) | су | | 1 | te of deliver | y Day Year | | | |
| | w requires that been signed b should be deta | þ | Part II. Other significant conditions co | 11 -4-5 | knee | infec | ton | 23e. Did to | es 2 No | 3 Proba | | | | |
| tal Re | | e Completed | 25. Was case referred to medical |) Dageles | | onery | C. Seaso | autop perfor | med? 2 No | prior to com death? | sy findings available pletion of cause of | | | |
| Division of Vital Records, | ling Phys | ation; To B | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | ER/Outpatient 28b. Time of Injury | 28c. Inju | ther: 4 🗆 Nursing | Home 5 Resid | ence 6 Oth | | | | | |
| Divis | i 를 들 드 | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | building, etc. (Spec | oify) | | | 28f. Location (S City or Tow | n, State) | | | | | |
| | To the Hospitel within 24 hours a To the Funerel I completely filled | Medical | 29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Exemo | rsicien: To the best of my kiner: On the basis of examinand manner stated. | nowledge, death nation and/or inv | estigation, in my | time, date and pla opinion, death or nse number | curred at the time, o | date and place, | and due to t | the cause(s) | | | |
| | 8 7 % 7 | _ | MA | -mop4 | 0 | | | | Voven | | | | | |
| | φ Sta | to | 30. Name and address of person who con the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of the character of t | ompleted cause of death (Ite Chier 49 32 Registrar's Sign | em 23a) (Type, F 40 Eas nature | stern/ | Avenue | , Salt: | more | mo | 21224 | | | |
| | Registr | - | NOV 2 9 20 | | K. Agos | Mes. | | | | | | | | |

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| | Physic | | 1. Decedent's Name (First, Middle, Las | PORRI | / | ato or boatin | 2. Date of Death Month Do | ay Year | 3. Time of Death |
| | /Medi Exami Funeral Director | | 4a. Facility Name (If not institution, give Bon Secour Security Number 6. Secour Security Number 6. Second Security Number 11 | 5 | | BALTIM der 1 Year If Under 24 Hr s Days Hours Mir | ore S. B. Date of Birth | 163661 41. | A pplace (State or Foreign intry) |
| \$44 | D | | Usual Residence of Decedent 10a. State 10b. County | 10c. Ci | ty, Town or Location | | NOV. 20,1 | | RTH CAROLINI 10d. Inside City Limits |
| | death with the Maryland ms 23a or 28a-1 show rount by ratified at | Irector | MARYLAUD 10e. Street and Number | JIA | 10f. | 3 ALTIHOR | | itizen of What Cou | 1 XYes 2 □ No intry? |
| 2-0036 | iges 1 and 2 should be filed within 72 hours after death with the Maryian nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Exami | d by Funeral Director | 2529 WES 11. Marital Status 1 Mi Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1 | If Yes, s | Cedent of Hispanic Origin? (ppecify Cuban, Mexican, Pue | Specify Yes or No- no Rican, etc.) | 14. Race - Ameri Black, White, Specify: BL | ican Indian, |
| 21215-(| ad within 72 h giene. er than "natu r the Medical | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) | College (1-4or 5+) | × 1 | sual Occupation work done during most of wi Tuse retired) AKER | orking 16b. F | Kind of Business/Ir | , |
| Maryland | iould be filed Mental Hygi harked other hatic event, I | To Be (| 17. Father's Name (First, Middle, Last) | /+ | OLLEY | WIL | ame (First, Middle, Maider | Sumame) | PFIELD |
| Baltimore, Mar | permit. Pages 1 and 2 sho Depertment of Health and Important: If item 27 Is ma any Injury or other traums | | 19a. Informant's Namy/Relationship (7) 20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify | PREMOVAL FRIEND 20b. F | Place of Disposition (femetery, crematory) | Vame of | AVE, BALT Date 20c. L | ocation - City or To | 2/2/6 own, State |
| Balti | permit. Depertm Importate any Injure once. | | 21. Signature of Funeral Service Licens | see wh | 22. Name | and Address of Figility | BROWELTE | BALTO, | RAL HOME |
| | Physician /Medical | | 23a. Part1. Enter the disease, or composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of th | ilications that caused the deat one cause on each line. a.ATHEROSCLE Due to (or as a conseq | ROTIC CO | | c or respiratory arrest, | | Approximate Interval Between Onset and Death |
| 8760, | exacuted be executed by sician and the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseq c. Due to (or as a conseq | · · | | | | |
| P.O. Box 687 | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | a. 23c. If yes, outcome of pregna 1 □Live birth 2 □Feta 4 □Pregnant at time of d 9 □ Unknown | I death 3 Ectopic | | | 23d. Date of delive | ery Day Year |
| | w requires that been signed I should be det | þ | Part II. Other significant conditions co | ntributing to death but not res | ulting in the underlying | g cause given in Part I. | 23e. Did tobacco | | |
| al Records, | ician: The law r certificate has be ector, page 2 sh | Completed | | | | | 24a. Was an autopsy performed? | prior to cor death? | psy findings available mpletion of cause of |
| Vital | | o Be | 25. Was case referred to medical examiner? | Hospital: | ER/Outpatient 3 | 1 015 | ath Check only one | | |
| o | g Phys er this eral di | 7: To | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of | 28c. Injury at Work? | dome 5 ☐ Residence 28d. Describe how injur | | y) |
| Ö | Attending I death. ctor: After y the funer | atio | 1 ■ Natural 5 □ Pending 2 □ Accident investigation | (Month, Day Year) | Injury M | Work? 1 ☐ Yes 2 ☐ No | | | |
| Division | To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At ho building, etc. (Specify | ome, farm, street, factory) | Dry, office | 28f. Location (Street an City or Town, State | id Number or Rura i) | Il Route Number, |
| | he Hospi n 24 hou he Funei pletely fil | Medical | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami | sician: To the best of my kno ner: On the basis of examina and manner stated. | wledge, death occurre tion and/or investigation | ed at the time, date and place on, in my opinion, death occi | e, and due to the cause(s) urred at the time, date and | and manner as st place, and due to | tated. the cause(s) |
| | To t To t | Σ | 29b. Signature and title of services | G | 5 | 9c. License number 3 |) | te signed (Month, i | Day, Year) |
| 12 | 3 | | 30. Name and address of person who co | | 23a) (Type, Print) | W BALTI | nores | T 21 | 223 |
| | Sta Registr | 7 | 31. Date (led World, Day, 2005 | 32. Registrar's Signa | tur (parle) | | | | |

| | | | | artment of Health and Martificate of Death | | 2005 38262 | |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------|--|
| | Physici /Medic | | 1. Decedent's Name <i>(First, Middle, Last)</i> Annie Frances Matilda Pitts | | 2. Date of Death Month 11 | Day Year 25 2005 10:22a ^M | |
| | Examir | | 4a. Fecility Name (If not institution, give street and number) 14709 Lancraft Ct. | 4b. City, Town, or Location of Death Darnestown | | 4c. County of Death Montgomery | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 212-63-3492 1 M 25 F 96 Yrs. |) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Y | 9. Birthplace (State or Foreign Country) Canada | |
| | Maryland I-f show | tor | 10a. State | | | 10d. Inside City Limits 1 ☐ Yes 2√CNo | |
| | h with the 23a or 28s | Funeral Director | 10e. Street and Number 14709 Lancraft Ct. | 10f. Zip Code 20874 | 10g | . Citizen of What Country? Canaga | |
| 36 | ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it is M. citcal E.S. cili ett. ust be nutilised at | þ | 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White | |
| Maryland 21215-0036 | vithin 72 hou ne. han *nature n M. dical E | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | edent's Usual Occupation to kind of work done during most of working DO NOT use retired) | ing 16 | b. Kind of Business/Industry | |
| and 2 | d be filed v ental Hygie ced other t c evant, IL | To Be Co | 2+ Tea 17. Father's Name (First, Middle, Last) Henry William Darling Cox | | e (First, Middle, Mar Wardley | , | |
| Mary | nd 2 shoul alth and Me 27 is marl ir traumati | F | 19a. Informant's Name/Relationship (Type, Print) Terry Lynne Pitts Sabin/daughter | ing Address <i>(Street and Number or Rura</i> 14709 Lancraft Ct. | al Route Number, C | ity or Town, State, Zip Code) | |
| altimore, | permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra ance. | | 20a. Method of Disposition 1 | matory or other place) | Date 2005 | c. Location - City or Town, State Cardston, Canada | |
| Balt | permit. Departr Importa | | Supul of Normann | 2. Na <i>me</i> and Address of Facility Rapp Funeral & Cr 933 Gist Av Silve | r Spring | MD 20910 | |
| TO STATE OF | Fnysician /Medical | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | ter the mode of dying, such as cardiac o | or respiratory arrest, | Approximate Interval Between Onset and Death Online | |
| | Examiner pupped particular properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the p | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (18-35-or ther) that initiated events | | | | |
| 8760, | icate be executed physician and s the burial-transit | dicai | resulting in death) Last Due to (or as a consequence of): d. | | | | |
| O. Box 6 | The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as | Physician/Me | | □Ectopic pregnancy □ Other (specify) | | 23d. Date of delivery Month Day Year | |
| ecords, P | quires that en signed b | by | Part II. Other significant conditions contributing to death but not resulting in the o | nderlying cause given in Part I. | | co use contribute to the cause of death? 2 No 3 Probably 4 XUnknown | |
| r | | Completed | | | 24a. Was an autopsy performed | | |
| or Vital | Physician: Th r this certificate ral director, pag | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie | | ne 5 🙀 Residence | e 6 ☐ Other (Specify) | |
| DIVISION | tending eath. tor: Afte the fune | Certification: | 27. Manner of Death 1 | Work? M 1 ☐ Yes 2 ☐ No | 28d. Describe how in | | |
| 2 | spital or At ours after d neral Direct filled in by | | 4 Homicide determined 200. Place of my knowledge, deat building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat | 1 | City or Town, S | · | |
| | To the Hospital o within 24 hours af To the Funeral Di completely filled in | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and titleyof certifier | vestigation, in my opinion, death occurre | ed at the time, date | and place, and due to the cause(s) Date signed (Month, Day, Year) | |
| | | | I what ration Wil | D06258 | | 11-28-2005 | |
| | 10 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Richard Katon 20528 Boland Farm Rd. | Germantown MD 208 | 76 | | |
| | Sta Registra | | NOV 2 9 2005 | de | | | |

Amend Item 20b per fh G849 11-29-05 tas of Death

State of Maryland / Department of Health and Mental Hygiene 0 5

Certificate of Death

Reg. No. 38263 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician essagni lin 5:05 PM ,2005 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth County of Death Examiner Baltimore Cromwell Home MORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-1-24. 5. Social Security Number 7. Age (In yrs. lest birthdey) Sex 1□ M 20 F 9. Birthplace (State or Foreign Country)

MARYLAWA **Funeral** 6. Sex 219-12 Months Days Hours Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f ahow ury or other traumetic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Director 101 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 21085 540 (by Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 D/No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 □ Yes 2 (No Specify 3 Widowed 4 □ Divorced White To Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) leuselerc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rurel Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health a important: If Item 27 is any injury or other tree 11-29-05 MD21083 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility BALTIMORE MO 21234. Pel 1. Enter the dis 2 se, or conf lica ons that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart fail, e. List unity one cause of each line. EVANS FUNERALCHAPEL, 8800 HARFORD RO Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its land as or injury Due to (or es e consequence of): Division of Vital Records. P.O. Box 68760. that initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 21 No 3 Probably 4 Unknown 1 Tes Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? rann this certificate 1LIYUS 1 ☐ Yes 2 ☐ No funerel director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menn r of Deeth nours efter death.

neral Director: After the filled in by the funere 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ucas 9855 30. Name end editess of person who completed cause of death (Item 23a) (Type, Print) Oinglin GAO, MD Hinore Loch 31. Dete filed (Month, Day, Year) 32 Registrer's Signature State NOV 2 Registra 2005

| | | | 1 - For State Registrar | State of Mai | ryland | | artmen rtificat | | | nd Me | | giene 0 | 5 3 | 88264 | |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------|---------------------------|---------------------------|---------------------------------|-----------------------------|-------------|-----------------------------------------|---------------------------------------|------------------------------|------------------------------------------|-----|
| | Physici | an | Decedent's Name (First, Middle, Last | X | | | | > | | | 2. Date of De. Month | ath Day | Year | 3. Time of Death | |
| 4 | /Media | | Dal-bara 1 | tnn | | | 1- | aye | | 1 | Jovembe | | 005 | 1050 A M | J |
| 1 | Examin | er | 4a. Facility Name (If not institution, give | 11 - | | | | | Location of | | | 4c. County | of Death | | |
| | - Formand | | 5. Social Security Number 6. S | | (In yrs. last | | If Under | | more If Under 2 | | | | 0.8141.1 | | _ |
| | Funeral Director | | 208-30-7738 | -W- | 6 | Yrs. | Months | Days | Hours | Min. | 8. Date of Birt (Month, Da 1-21-1 | y, Year) | 9. Birthpla Country | ce (State or Foreign y) | 7 |
| | ט | | Usual Residence of Decedent | | | | | | | | 1 21 1 | . 739 | | PA | _ |
| | anylar show | _ | 10a. State 10b. County | | 10c. City, T | | | | | | | | 100 | d. Inside City Limits | |
| | 8a-f | ecto | MD Anne Aru | ldel | L | inth | icum | | | | | | | 1 ☐ Yes 2A☐ No | |
| | 72 hours after death with the Maryland Insture!, or Itame 23e or 28e-f show dical Examiner must be ruillied at | Funeral Director | 10e. Street and Number | | | | 10f. Zip | 2109 | 20 | | | 10g. Citizen of W | | y? | |
| | eath | erai | 105 E. Maple Roa | 12. Was Decedent Ev | or in II S | 12.1 | Non Deser | | | :-0 (0 | 2 | 14.5 | USA | | |
| ' 0 | r Itan | Fun | 1 ☐ Never Married 2 ☑ Married | Armed Forces? | | 13. 1 | f Yes, spec | offy Cubar | n, Mexican, | Puerto R | ify Yes or No- ican, etc.) | Black | - Americar c, White, et | | |
| 030 | rei', o | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 | 1 ☐ Yes | 2 🔀 No | Specify: | | | Specify: | whi | ite | |
| 21215-0036 | 72 ho | Completed | 15. Decedent's Ed (Specify only highest gra- | ucation de completed) | 1 | 6a. Deced | dent's Usua | al Occupa | tion uring most o | of working | , | 16b. Kind of Bu | siness/Indu | stry | _ |
| 12 | vithin ne. hen | mpl | Elementary/Secondary (0-12) | College (1-4or 5+) | | life. L | DO NOT us | se retired) | | or working | | Health | Care | 5 | |
| 20 | Hygie Hygie thert nt, in | S | 17. Father's Name (First, Middle, Last) | 4 | | regis | tere | - | | No. N.I. | · · · · · · · · · · · · · · · · · · · | | | | _ |
| and | d be sold o | To Be | George Victo | r (| Salva | + | | | | | | Maiden Sumame | 9) | | |
| Maryland | shoul nd Me mark | ř | 19a. Informant's Name/Relationship (7 | · | | | | (Street a | | | Marc | hes r, City or Town, S | State Zin C | inda) | |
| | alth a 27 le | | Mr. Stephen F. Pay | | | | | | | | | MD 21090 | | 006/ | |
| ore, | of He of He rothe | | 20a. Method of Disposition | | 20b. Place ceme | | | | | Da | | 20c. Location - 0 | | n, State | - |
| Ĕ | Pag nent ant: If ury or | | 1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | I IOMOVAL II OILI OLALO | Chesa | apeak | e Cre | mati | on 1 | 1/21 | /2005 | Stevens | ville | , MD | |
| Baltimore, | permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If then 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Examiner must be notified at once. | | 21. Signa ure of Funeral Service Licen. | 10 MO12 | 3/04 | | | | of Facility | OTH | gleton | Funeral e MD 210 | Home | P.A. | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | lications that caused th | ne death. | Do not ente | er the mod | e of dying | , such as ca | ardiac or i | respiratory ari | rest, | A | pproximate | |
| | Physician | | Immediate Cause (Final disease or condition | Ac. + | . V | Nua | 1000 | nou | 210 | out. | emig | | l c | nterval Between Inset and Death | |
| / | /Medical | | resulting in death) | a. Due to (or as a c | consequence | | roge | /10/00 |) [| | corrig | | 7 | menths | _ |
| | Examiner | | Sequentially list conditions. | | nicro | |) 1 | 3act | erem | ia | | | 0 | LWEKS | |
| | sit a | ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | consequenc | ce of): | | | | | | | | | |
| | and and II-tran | Examiner | that initiated events resulting in death) Last | c | onsequenc | ce of): | | | | | | | | | |
| 8760, | The law requires that the death certificate be executed te has been signed by the attending physician and age 2 should be detached for use as the burial-transit | alE | | | | 0.7. | | | | | | | | | |
| 89 | ificate g phy as the | Physician/Medical | | a | | | | | | | | | | | - |
| Вох | leath certific attending pl | Z/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of | | | | | | | | 23d. Date | of delivery | | |
| 0 | deat ne atte | sicia | in the past 12 months? 1 ☐ Yes 2 ☑ No | 1 Live birth 2 { 4 Pregnant at time | | | Ectopic pre Other (spe | | | | | Mont | | ay Year | |
| о. О | that the de led by the a detached f | Phy | 9 Unknown | 9□ Unknown | | | | | | | | | | | _ |
| Ś, | res tha signed be de | Ď | Part II. Other significant conditions co | ntributing to death but r | not resulting | g in the un | derlying ca | iuse giver | in Part I. | | 23e. Did to | bacco use contrib | | | |
| 5 | w require been sli should t | Completed | | | | | | | | | 1 🗆 Y | es 2. ENO 3 | Probabl | ly 4 ∐Unknown | - 5 |
| 3ec | The law cate has b page 2 s | ğ | | | | | | | | | 24a. Was a autops | sv pri | or to comp | findings available letion of cause of | |
| ā | | | | | | | | | | | perfòri 1 ☐ Yes | | ath? Yes 2 | □ No | |
| = | Physician: This certificated in director, pr | Be | 25. Was case referred to medical examiner? | Hospital: | | | | 0.00 | | | Check only on | | | | |
| ō | eral d | 2 | 1 Yes 2 No | 28a. Date of Injury | 285 | Outpatient o. Time of | | ~ | 4 🔲 140151 | | | ence 6 Other | | | _ |
| 0 0 | Attending Physician: r death. sctor: After this certifica by the funeral director. | tion | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Y | ear) | Injury | м | 3c. Injury a Work? 1 ☐ Ye | n" es 2∐No | | a. Describe in | ow injury occurred | , | | |
| | r Attender death | Hica | 3 Suicide 6 Could not be determined | 28e. Place of Injury | - At home, | farm, stre | et, factory, | | | | Location (St | reet and Number | or Rural R | oute Number. | _ |
| ā | pltat or urs afte eral Dir illed in | Certification; | | building, etc. (| | | | | | | City or Fowi | n, State) | | | |
| | To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by | edicai | 29a. Certifier 1 Certifying Phy check only one) 1 Medical Exami | sician: To the best of n ner: On the basis of ex and manner stated | tamination a | dge, death and/or inve | occurred a estigation, | it the time in my opii | , date and p nion, death | occurred | d due to the ca at the time, d | ause(s) and manr ate and place, an | ner as state d due to the | ed. e cause(s) | |
| | To To Con | Σ | 29b. Signature and title of certifier. | 1// | | | 29c. | License | number | 1 | 1 | 9d. Date signed (| | v, Year) | |
| 7 | 0 | | y g. war | | | | 1 | اعار | 66 |) | 1 | Jovembo | ~ 10 | 1,2005 | |
| 6 | 1 | | 30. Name and address of person who of | ompleted cause of deat | h (Item 23a | a) (Type, P | Print) A | 0 51 | reet | 7 | altma | e Man | 1000 | 21787 | |
| Í | Stat | е | 31. Date filed (Month, Day, Year) | 32. Fjegistrar's | | | | 1 | 6.61 | ال | · · · · · · · · · | · MAN | INVICA | 2140 | _ |
| | | ır | 0 0:26 | 105 6000 | 186 | 100 | 344 | | | | | | - | | - 1 |

| | | 1 - State | State of Ma | aryland | | artment of H rtificate of L | | - | 7 11 11 5 | 38265 |
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| | | Registrar 1. Decedent's Name (First, Middle, La | st) | | | rimodic or E | Journ | 2. Date of Dea | Reg. No. | 3. Time of Death |
| Physi | cian | William Penkows | | | | | | November November | Day Year | |
| /Med | | 4a. Facility Name (If not institution, give | | | | 4b. City, Town, or | Location of Dea | | 4c. County of Dea | |
| Exam | iiner | Holy Cross Hosp | | | | Silver | | | Montgome | |
| Funare | 1 | 5. Social Security Number 6.5 | | e (In yrs. la | st birthday, | If Under 1 Year | If Under 24 Hrs | 8. Date of Birt | h 9. Bi | thplace (State or Foreign ountry) |
| Funera Directo | | 046-18-4817 | 1⊠M 2□F | 81 | Yrs. | Months Days | Hours Mir | Dec. 16 | y, Year) 9. Bi | necticut |
| | | Usual Residence of Decedent | | | | | | | | |
| rylan | | 10a. State 10b. County | | 10c. City, | Town or L | ocation | | | | 10d. Inside City Limits |
| e Ma | 5 | Maryland Montgom | ery | Kens | ingto | n | | | | 1 X Yes 2 No |
| or 28 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of What C | ountry? |
| d 21213-UU36 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Exercitment was be notified at | -E | 11104 Mitscher S | | | | 20895 | | | United St | |
| er de | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | | . 13. | Was Decedent of Hi If Yes, specify Cuba | ispanic Origin? (in, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | 14. Race - Am Black, Wh | |
| s afte | by F | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 XYes 2 ☐ N If Yes, Give Year or Dates: | NO WW | 11 | 1□ Yes 2⊠ No | Specify: | | Specify: W | hite |
| bour le | pa pa | 15. Decedent's E | | | 16a Dece | dent's Usual Occupa | ation | 1 | 16b. Kind of Business | /Industry |
| 72 in 72 | Completed | (Specify only highest gr | ade completed) | | (Give | kind of work done of DO NOT use retired | during most of wo | orking | TOD. TAING OF DESIRES. | villadatiy |
| with with the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the | i ii | Elementary/Secondary (0-12) | College (1-4or 5 4 | 5+) | | ian Lingu | | | Federal Go | vernment |
| ING 21213-UU30 be filed within 72 hours after death with the Marylan tall Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, If a Madical Exception | Be | 17. Father's Name (First, Middle, Last | ') | | | | 18. Mother's Na | me (First, Middle, | Maiden Sumame) | |
| should be and Mental marked o | 10 B | Stepan Penkowsky | • | | | | Antoin | ette Che | rtok | |
| Maryland 21213-UU36 d 2 should be filed within 72 hours aff th and Mental Hygiene. ?? Is marked other than "natural", or traumatic event, the Medical Exural | - | 19a. Informant's Name/Relationship | | | 19b. Mail | ng Address (Street a | and Number or F | iural Route Numbe | or, City or Town, State, | Zip Code) |
| and 2 and 2 ealth a n 27 Is | | Peyton Penkowsk | y/ Wife | | 11104 | Mitscher | Street | , Kensin | gton, Mary | and 20895 |
| Baltimore, Maryla permit. Pages 1 and 2 should b Department of Health and Ment Important: if item 27 is marked any injury or other traumatic e | | 20a. Method of Disposition | | 20b. Pla | ce of Disp | osition (Name of matory or other place | e) Nov | Date ember | 20c. Location - City o | |
| Page ent o nt: # | | 1 ☐ Burial 2 ☆ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | □Removal from State fy) | Crem | Montg | osition (Name of matory or other plac omery um, Inc. | 27. | 0005 | ethesda, M | arvland |
| mit. I | œi I | 21. Signature of Funeral Service Lice | nsee S | 1020 | . 2 | 2. Name and Addres | s of Facility | bert A. | umphrey Fu | neral Home/ |
| in page in | ä | 1 BETON | | M0135 | 6 R | ckville, | Marylan | d "20850 | -2805 AVE | neral Home/ enue |
| 11911 | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | plications that caused | the deeth. | Do not en | ter the mode of dyin- | g, such as cardia | ac or respiratory ar | rest, | Approximate Interval Between |
| Physicia | , | Immediate Cause (Final | Pneum | | | | | | | Onset and Death |
| /Medica | | disease or condition resulting in death) | Due to (or as | | | | | | | |
| Examine | r | | | , | , | | | | | |
| | je je | Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury | Due to (or as | a conseque | ance of): | | | <u> </u> | | |
| uted d ansit | Examiner | Cause (Disease or injury that initiated events | c. | | | | | | | |
| 60, be executed ician and burial-transit | | resulting in death) Last | Due to (or as | a conseque | ence of): | | | | | |
| 760 te be e ysician e buriz | ca | | _ d | | | | | | | |
| 68 tifficat ng phy as th | led | I S S S S S S S S S S S S S S S S S S S | | | | | | | | |
| BOX eath cert attendin for use | Na Na | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome 1 ☐ Live birth | | | ☐Ectopic pregnancy | | | 23d. Date of de | |
| deat deat ne att | Sich | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4☐Pregnant at 9☐Unknown | | | Other (specify) | | | Month | Day Year |
| P.O nat the d by th letache | Physician/Med | 9 Unknown | | | | | | | | |
| | by | Part II. Other significant conditions | contributing to death b | ut not resul | ting in the i | inderlying cause give | en in Part I. | | bacco use contribute t | |
| Records, he law requires the has been signed age 2 should be considered. | | | | | | | | 1 🗆 Y | res 2∐No 3∐P | robably 4 🕅 Unknown |
| as a 6 | be d | | | | | | | 24a. Was | sv prior to | utopsy findings available completion of cause of |
| | Completed | | | | | | | perto 1 ☐ Yes | rmed? death? 2√2 No 1 ☐ Ye | s 2 No |
| r Vital Reysician: The is certificate his director, page | Be (| 25. Was case referred to medical examiner? | | | | | | ath (Check only o | ne) | |
| of V Physic this ce al dire | 2 | 1 ☐ Yes 2 🔀 No | Hospital: 1 Inpatie | ant 2 🗆 E | R/Outpatie | nt 3₺ DOA Othe | er: 4 🗆 Nursing | Home 5 ☐ Resid | dence 6 Other (Spe | ecify) |
| Division of lor Attending Phy after death. Director: After this in by the funeral d | | 27. Manner of Death 1 XNatural 5 ☐ Pending | 28a. Date of Inju (Month, Da | ry y Year) | 28b. Time o Injury | Worl | k? | 28d. Describe h | low injury occurred | |
| SiO eath. or: A | catt | 2 Accident investigation | | | | | Yes 2 □ No | | | |
| Division or Attence after death Director: | Certification; | 3 Suicide 6 Could not determined | | | | reet, factory, office | | 28f. Location (S City or Tov | Street and Number or F vn, State) | ural Route Number, |
| | | | | | | | | 1 | | |
| Dital o | | | | of my know | | | | | cause(s) and manner a date and place, and du | |
| Hospital of the hours aff | | (Check only 2 Medical Exe | miner: On the basis of | f examination | | | | | | |
| the Hospital of thin 24 hours affithe Funeral Dimpletely filled in | | (Check only 2 Medical Exe | | f examination | | 29c. License | e number | | 29d. Date signed (Mon | th. Dav. Yearl |
| Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | Medical Ce | (Check only 2 Medical Exe | miner: On the basis of | f examination | | 29c. License | | | 29d. Date signed (Mon | |
| To the Hospital or within 24 hours all to the Funeral D completely filled in | | (Check only 2 Medical Exe one) 29b. Signature and little of certifier | miner: On the basis of and manner sta | f examination ated. | | D | e number 24348 | | | th, Day, Year) |
| To the Hospital of within 24 hours all To the Funeral D completely filled in | | (Check only 2 Medical Execution) 29b. Signature and little of certifier 30. Name and address of person who | miner: On the basis of and manner sta | f examination ated. | 23a) (Type | Print) | 24348 | | 11-2 | 10,2005 |
| (0t) | Medical | 29b. Signature and little of certifier 30. Name and address of person who Steven Grufferman | miner: On the basis of and manner stands of the completed cause of days. | f examination and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of | ^{23a) (Type} rest | Print) | 24348 | | 11-2 | 10,2005 |
| (0t) | Medical | 29b. Signature and little of certifier 30. Name and address of person who Steven Grufferman 31. Date filed (Month, Day, Year) | o completed cause of d., M.D., 15 | f examination and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of | 23a) (Type rest ire | Print) Glen Road | 24348 | | 11-2 | 10,2005 |
| (0t) | Wedical | 29b. Signature and little of certifier 30. Name and address of person who Steven Grufferman | o completed cause of d., M.D., 15 | f examination and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of | ^{23a) (Type} rest | Print) Glen Road | 24348 | | 11-2 | 10,2005 |

| | | | For State | State of Maryla | | | Mental Hygid | ene | |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------|----------------------------------|--------------------------------------------------------------|
| | #E | - | Registrar 1. Decedent's Name (First, Middle, La | st) | Certifica | ate of Death | Reg | 1. NR. | 5 38266 3. Time of Death |
| 34 | Physic /Medi | | Dionne | - Phillie | 20 | | Workin Lev | | (ear)005 /1:02 PM |
| | Exami | ner | 4a. Facility Name (If not institution, giv | e street and number) | 4b. Ci | y, Town, or Location of De | | 4c. County of | |
| | Funeral | | 5. Social Security Number 6. S | | | der 1 Year If Under 24 H | | | Birthplace (State or Foreign |
| 樂 | Director | | 243-19-2523 1 Usual Residence of Decedent | OM 200 31 | Yrs. Month | s Days Hours Mi | Sept. 23 | 1974 1 | lorth Carolina |
| | yland how | | 10a. State 10b. County | 10c. C | ity, Town or Location | | | , | 10d. Inside City Limits |
| | he Ma | Director | Maryland N/ | | Baltimi | | | | 1 Yes 2 □ No |
| | 3a or | i Dir | 10e. Street and Number | brook C: | calo 10f. | 2ip Code | 100 | . Citizen of Wh | at Country? |
| | tems 2 | Funeral | 11. Marital Status | 12. Was Decedent Ever in L Armed Forces? | J.S. 13. Was Dec | cedent of Hispanic Origin? Decify Cuban, Mexican, Pue | (Specify Yes or No- | | American Indian, White, etc. |
| 336 | urs afte | | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | | 2 No Specify: | , , , , , , , , , , , , , , , , , , , , | Specify: | Dlank |
| 215-0036 | be filed within 72 hours after death with the Maryland nat Hygiene. d other then "natural", or items 23e or 28e-f show event. The Medical Exercitar must be recitified at | Completed by | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16a. Decedent's Us | sual Occupation work done during most of w | orkina 16 | b. Kind of Busi | ness/Industry |
| 2121 | within iene. then | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NOT | use retired) | 14 | andia | anned Agency |
| | be filed tal Hygis d other | BeC | 17. Father's Name (First, Middle, Last) | | Vall | 18. Mother's N. | ame (First, Middle, Ma | iden Sumame) | appea Agency |
| Maryland | | 2 | James Do | naldson | 401-14-11 | Ethe | line f | Hillif | 05 |
| | ulth ar 27 ts r trau | ľ | Ms. Etheline | Phillips | 1506 I | ss (Street and Number or F | nural Route Number, C | Palt | ate, Zip Code) |
| ore | 000 | | 20a. Method of Disposition 1 W Burial 2 Cremation 3 | Removal from State | Place of Disposition (A | ame of rother place) | Date 20 | c. Location - Ci | ty or Town, State |
| Baltimore, | | | 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licer | 1) | MIT. Car | me I | 0/2007 T |)unde | alk, Md. |
| Ba | permit. Departr Import | | Joseph (| X. KUM | Josep | WINDYSSI | -uneral t | gme F | . A. |
| | | | 23a. Part Enter the disease, or comshook, or heart failure. List only | plications that caused the deal | th. Do not enter the m | | ac or respiratory arrest | | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a consec | es Mellitu | 5 | | | Onset and Death |
| 4 | Examiner | | Sequentially list conditions. | . Seize | ice Dison | der | | | |
| | nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Due to (or as a consec | quence of): | | | | |
| Ö, | cate be executed bhysician and the burial-transit | Exa | that initiated events resulting in death) Last | Due to (or as a conseq | juence of): | | | | |
| 8760 | death certificate be executed e attending physician and id for use as the burial-transit | dical | • | d | | | | | |
| Box 6 | eath certific attending p | ın/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta | | | | 23d. Date of | of delivery |
| | he deat | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4☐ Pregnant at time of d | | | | Month | - |
| P.O. | requires that the d een signed by the hould be detached | by Ph | Part II. Other significant conditions of | ontributing to death but not res | ulting in the underlying | cause given in Part I. | 23e. Did tobac | co use contribu | ite to the cause of death? |
| Vital Records, | w requires been sign should be | ted b | | | | | 1 ☐ Yes | 2 No 3 | Probably 4 Unknown |
| 3ec | elaw hasb le2sl | Completed | | | | | 24a. Was an autopsy | 24b. Wei | re autopsy findings available r to completion of cause of |
| tal | | 0 | 25. Was case referred to medical | | | — 36 Place of De | performed 1 Yes 2 2 ath Check only one | | tn? Yes 2□ No |
| | Physician: this certific ral director, | ToB | 1 163 2 5 140 | | ER/Outpatient 3 0 | Ott | Home 5 Residence | e 6 Other (| (Specify) |
| ouo | ding P h. After I funera | tion; | 27. Manner of Death 1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how | njury occurred | |
| Division of | r Attending er death. rector: After by the fune | Certification; | 3 Suicide 6 Could not be determined | | ome, farm, street, facto | | 28f. Location (Stree | t and Number o | or Rural Route Number, |
| ۵ | Hospital or A 24 hours after Funeral Directely filled in by | | | | | | City or Town, S | | |
| | - (4 - 0) | edicai | (Chack only one) | vsician: To the best of my known or the basis of examina and manner stated. | wiedge, death occurre tion and/or investigation | d at the time, date and plac n, in my opinion, death occ | e, and due to the caus urred at the time, date | e(s) and manne and place, and | er as stated. due to the cause(s) |
| | To the within To the comple | Ž | 29b. Signature and title of certifier | 191 | | dc. License number | | Date signed (A | Month, Day, Year) |
| } | 1 | | 30. Name and address of person who o | Sinton | 220) (75 5 : :: | D0053539 | | 11/22/ | 05 |
| 0 | L ' | | Robert Lin | fon IT MI | Union | Doossssy Memorial H | 65 pizal | | |
| | Sta Registr | _ | 31. Date filed (Month, Day, Year) NOV 2 9 201 | 37 Registrar's Signa | ture facts | | 7 | | |

| | | | 1 - For State Registrar | State of Maryla | | artmer rtificat | | | nd Menta | | ene () | 05 | 38267 |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------|------------------------|-----------------------|----------------------|------------------------------------|--------------------------------|-------------------------|----------------------------------------|----------------------------------------------------|
| * | Physici | ian | 1. Decedent's Name (First, Middle, Last, Laura Elizabet | | | | | | 2. Date Mor Noven | of Death | 2 ^{Day} | 2ď 85 | 3. Time of Death |
| 1 | /Medi Examir | | 4a. Facifity Name (If not institution, give | • | | 4b. City. | Town, or | Location of | | DEL | | nty of Death | 5:50p м |
| · Anna | LAGITIII | | FutureCare Cherry | | | | | stown | | | | Baltim | ore |
| | Funeral | | 5. Social Security Number 6. Sec. 478-12-0695 | 7. Age (In yrs | iast birthday) Yrs. | If Under Months | n 1 Year Days | If Under 24 Hours | Min. 8. Date | of Birth | (89r) | 9. Birthp Cour | oface (State or Foreign |
| - \$P. | Director | | Usual Residence of Decedent | | | | | | AUG | 19 1 | 908 | | NE NE |
| | arylan show | _ | 10a. State 10b. County | | ity, Town or Lo | | | | | | | 1 | Od. Inside City Limits |
| | the M 28a-f | ecto | MD Baltimo | re C | wings l | Mills 10f. Zip | | | | 10 | 0 | | 1 ☐ Yes 2 X No |
| | 3a or | Funeral Director | 104 Pleasant Rid | ge Drive | | 101. 21 | 211 | 17 | | 109 | . Citizen | of What Cour | ntry? |
| | ems 2 | Iner | | 12. Was Decedent Ever in U Armed Forces? | J.S. 13. \ | Was Dece | dent of Hi | spanic Origin | n? (Specify Yes Puerto Rican, e | or No- | | Race - Americ | |
| 36 | rs afte | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 🕅 No If Yes. Give | | 1 ☐ Yes | | Specify: | aono moan, e | | Spe | Black, White, c <i>ify:</i> bla | |
| 21215-0036 | be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23e or 28e-f show event, I're Medical Exerdiatr resal by ricillise at | ted b | 15. Decedent's Edu | | 16a. Deced | dent's Usua | al Occupa | ition | | 16 | | Business/Inc | |
| 215 | within 7 iene. • than *n | Completed | (Specify only highest grade Elementary/Secondary (0-12) | e completed) College (1-4or 5+) | (Give | kind of wo DO NOT u | rk done d | uring most o | of working | | rivat | | , |
| 121 | filed withi Hygiene. Other ther | | 17. Father's Name (First, Middle, Last) | | Domes | stic | | 10 Mathada | None (Cint) | | ousel | | |
| lanc | ould be f Mental I arked of | To Be | Unknown | | | | | Sara | s Name <i>(First, M</i> ah Nev | ^{лідаів, ма} man | iden Sum | ame) | |
| Maryland | s 1 and 2 should f Health and Men itam 27 is marke other traumatic | - | 19a. Informant's Name/Relationship (Ty | pe, Print) | 19b. Mailin | g Address | (Street a | nd Number | or Rural Route | Vu <i>mb</i> er, C | ity or Tov | vn, State, Zip | Code) |
| | 1 and 2 Health am 27 i | 3 | Alnora Evans - da | 9 | _ | | | - | Drive, | Owing | gs Mi | 11s, N | 4D 21117 |
| Baltimore, | 0 0 | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R | | Place of Disponentery, cren | | | | Date /000 | | | n - City or To | |
| Ħ | | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License | | | . Name an | d Addres | s of Facility | ./26/200 | 100 | | ville, | MD |
| B | permit. Departimport. any inj | | 1 So Hale | M009 | | 7 17 , | Stepl | hen D. Pasti | Lohrma res Dri | nn, | PA Towsc | on. MD | 21286 |
| | | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only on | ie cause on each line. | | er the mod | e of dying | , such as ca | rdiac or respira | tory arrest | | ., | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a consec | imer | s D | rise | 956 | | | | | 0.001 0.10 00001 |
| | Examiner | | Sequentially list conditions | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1401100 017. | | | | | | | | |
| | ed sit | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec | uence of): | | | | | | | | |
| · · | execut n and al-trar | Examiner | that initiated events resulting in death) Last | Due to (or as a consec | uence of): | | | | | | | | |
| 8760, | death certificate be executed e attending physicien and ad for use as the burial-transit | lcal | | J | | | | | | | | | |
| 39 x | leath certifica attending ph | Med | IF FEMALE: | 0-16 | | | | | | | | | |
| Вох | eath c attend | Physician/Med | in the past 12 mopths? | 3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o | Ideath 3 | Ectopic pro | | | | | 1 | Date of delive Nonth | ry Day Year |
| P.O. | to the c by the tachec | hys | 1 ☐ Yes 2 ŒNo 9 ☐ Unknown | 9□ Unknown | | | | | | | | | |
| | law requires that the deas been signed by the as 2 should be detached for | by P | Part II. Other significant conditions con | _ | ulting in the un | iderlying ca | ause givei | n in Part I. | 23e. | Did tobac | co use co | ntribute to th | e cause of death? |
| örc | been | eted | Chronic Atrial F | | <i>a</i> - | | | | _ | - | 2 No | 3 Proba | ably 4 Denknown |
| of Vital Records, | The law ate has page 2 s | Completed by | peripheral vascu | 1101 11300 | 26 | | | | _ 24a. | Was an autopsy performed | | . Were autop prior to con death? | esy findings available apletion of cause of |
| ital | an: T tificate tor, pa | 0 | 25. Was case referred to medical | | | | | 26 Place of | Death Check | ∕es 2ဩ | | 1 Yes | 2□ No |
| <u>}</u> | hysici his cer I direc | To B | examiner? 1 ☐ Yes 2 ☑ No | ospitaf: 1 ☐ Inpatient 2 ☐ | ER/Outpatient | 3 DO | | | ng Home 5 | | e 6 □O | ther (Specify |) |
| סעכ | ling P | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of fnjury (Month, Day Year) | 28b. Time of fnjury | | 8c. Injury : Work? | at ? | 28d. Desc | cribe how i | n _f ury occi | urred | |
| Division | Attending Physician: r death. sctor: After this certifics by the funeral director. | ficat | 2 Accident investigation 3 Suicide 6 Could not be determined | 28e. Place of fnjury - At he | ome farm stre | M factory | | es 2□No | | ion (Stree | t and Nun | nhor or Pumi | Route Number, |
| É | in Diffe | Certification: | 4 Homicide determined | building, etc. (Specif | y) | | , 011100 | | City | or Town, S | tate) | iber or rigial | TIOUTO PAULIDOI, |
| | Hospital 24 hours Funeral I tely filled | Medical | 29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin | ician: To the best of my knower: On the basis of examina | wledge, death tion and/or inv | occurred a | at the time | o, date and p | lace, and due to | the caus | e(s) and n | nanner as sta | ited. |
| | To the Youthin 2 To the Complei | Med | one) 29b. Signature and title of certifier | and manner stated. | | | License | | | | | ed (Month, D | |
| | - s + ō | | > Karen L. B. | alret, M.D. | | | | 58671 | 6 | | _ | | ,2005 |
| | 2 | } | 30. Name and address of person who cor | mpleted cause of death (Iten | n 23a) (Type, F | Print) | | | | | | | |
| | | | Karen L. Babitt, A | 32. Registrar's Signa | n Stree | et, s | uite | 200 | Ke is to | 1240 | wn | MDS | 1136 |
| | Sta Registra | | NOV 2 9 2005 | 32. Registrar's Signa | Consult. | , | | | | | | | |

| JM | | | State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health And Maryland / Department of Health And Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Depa | Mental Hy | giene Reg. No. 005 | 38268 |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------|
| | Physici | | Decedent's Name (First, Middle, Last) Michael Charles Rabuck | 2. Date of Dea Month November | Day Year | 3. Time of Death 6:10 p M |
| | /Medi Examir | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | 4c. County of Deat | |
| 9 | *** | St. | Baltimore Washington Medical Center Glen Burnie | | Anne Aru | nde1 |
| 63 | Funeral Director | | 5. Social Security Number 218-88-0202 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) 1 ft Under 1 Year 1 ft Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day Sept. 20 | h , Year) 9. Birt , 1976 Ba I t | hplace (State or Foreign untry) |
| e | pue * | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | ,20,0 | 10d. Inside City Limits |
| | Manylan I-f show Iled at | tor | Maryland Baltimore County Dundalk | | | 1 ☐ Yes 2 → No |
| | or 288 | Director | 10e. Street and Number 10f. Zip Code | | 10g. Citizen of What Co | • |
| | leath w | Funerai | 7303 School Ave. 21222 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St | pacify Vec or No- | United St | |
| 920 | should be filed within 72 hours after death with the Maryland ind Mental Hyglene. I marked other than "natural", or Items 23s or 28s-f show umatic event, the Medical Examinar must be notified at | b | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: | Rican, etc.) | Black, White | |
| 2-0 | natur | Completed | 15. Decedent's Education (Specify only highest grade completed) [Secondary (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired) | king | 16b. Kind of Business/ | ndustry |
| 2121 | withir jiane. r than | ошр | Elementary/Secondary (0-12) College (1-4or 5+) Infe. DO NOT use retired) 10 N/A Contruction | | Home Impr | ovements |
| nd ? | be filed within 72 ho stal Hygiene. of other than "natus event, the Madical | BeC | 17. Father's Name (First, Middle, Last) 18. Mother's Name | | Maiden Surname) | |
| Maryland 21215-0036 | should be nd Mental marked o | ပ | Charles Lawrence Rabuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rule) | en Fitzpa | | |
| | s 1 and 2 should f Health and Mer item 27 Is marke other traumatic | | | dalk, Ma: | | _ |
| 3altimore, | permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra QDCE. | | cemetery, crematory or other place) | | 20c. Location - City or | |
| Itim | nit. Pa artmen ortant: injury | | 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Service Licensee | | | |
| Ba | permit. Departr Importe any inju | | 21. Signature of Funeral Service Licenseef Jan, As. Peaceful Alternative 2325 York Road Times. | ves Fune: nonium. N | ral&Cremati Maryland 2 | on Ctr.,P.A 1093 |
| | | | 23a. Part. Enfertife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or healt failure. List only one cause on each line. | or respiratory arr | rest, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) Narcotic Intoxication Due to (or as a consequence of): | | | Onset and Death |
| | Examiner | | | | | |
| | ted | Examiner | Tany, leading to immediate Cue to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or injury) | | | |
| o, | be executed sician and burial-transit | | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | |
| 8760, | cate be exphysician the burial | dicai | d | | | |
| 9 x | eath certific attending p | /Med | IF FEMALE: 23b. Was decedent overcast. 23c. If yes, outcome of pregnancy | | 22d Date of dall | |
| P.O. Box | Attending Physicien: The law requires that the death certificate be executed redath. r death. sctor: Atter this certificate hes been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 | | 23d. Date of deline Month | Day Year |
| Is, P | ires that signed b | by | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | bacco use contribute to | |
| corc | w requir been s should | ieted | | 1 ☐ Ye | | bably 4 Unknown |
| Re | The lay | Completed | | autops | y prior to,c | opsy findings available ompletion of cause of |
| Vita | icien; Th certificate ector, pag | Be | 25. Was case referred to medical examiner? 157 Vas 2 No. Hospital: Description of Table No. Other: | h Check only on | Θ) | |
| ŏ | ding Physicien; n. After this certific funeral director, | n: To | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at | | ence 6 Other (Spec | |
| sion | tending Faath. for: After the funer | catio | 2 □ Accident Investigation 11-18-05 9:20 A M 1 □ Yes 2 \(\frac{1}{2}\)No | | uı | nk |
| Division of Vital Records, | To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Certification: | 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Momer 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Shower | City or Town | reet and Number or Run ^{n, State} Maryland on, Jessup, | l House of Md |
| | Hosp 24 hou Fune etely fil | edicai | 29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2⅓ Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated. | and due to the ca red at the time, da | ause(s) and manner as ate and place, and due | stated. to the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier 29c. License number | 29 | 9d. Date signed (Month, | Day, Year) |
| | | | Margine (hels hell m) OCME | N | November, 20 |), 2005 |
| | N | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YRYMA P. KREW 111 Penn Street | t Balti | more Marv1 | and 21201 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | , , , , , , , , , , , , , , , , , , , , | |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November RICHARD $_{
m LEE}$ RANDALL /Medical Facility Name (If not institution, give street and num 4c. County of Death Examiner Baltimore Lit N/A 5. Social Security Number B. Date of Birth (Month, Day, JAN 18 **Funeral** yrs. last birthday, 9. Birthplace (State or Foreign Days Hours 1**XX** 2□ F Director 219-52-3270 Yrs 56 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Director 1X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1822 WOODYEAR STREET Funerai 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. illed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXVo þ 3 ☐ Widowed 4 Divorced Specify: Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. int: if Itam 27 ie marked other than 12th grade LAUNDRY MERCY HOSPITAL other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 HARRY RANDALL KATHLEAN SNEAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya C. Randall/Daughter 6141 St. Regis Rd., Baltimore, Md., 21206 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If It any injury or o 1X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) MT CARMEL CEMETERY 12-02-05 DUNDALK, MARYLAND 21. Signature of a ral a price kige 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE Leaur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death P.O. ed by the a detached f 5 Other (specify) 9 Unknown 9 Unknown signed by Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown peed : 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 2□ No 1 Yes 2 No 1 Yes or Attending Physician: After this certification, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending envestigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year) erson who completed 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

NOV 2 9 2005

Physician

/Medical

Examiner

Directo

Funerai

ģ

Funeral Director

11. Marital Status

1 Never Married 2 Marned

15. Decedent's Education (Specify only highest grade completed)

tX Burial 2 ☐ Cremation 3 ☐ Removal from State

f Funeral Service Licensee

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Edward James Roper 19a. Informant's Name/Relationship (Type, Print)

Leo Roper-Brother

4 ☐ Donation 5 ☐ Other (Specify)

12th grade

20a. Method of Disposition

Immediate Cause (Final

direase or condition resulting in death)

| | | | | | | | | | | • • • • |
|---------------------------|-------------------|-----------------------|--------|-----------------------------|-------------------------------|-----------------------|--------------------|---------------|------------|------------------------|
| | Plea | se Type or | Prin | t in Black Inc | delible Ink. | Ensure A | Il Copies A | re Leg | ible. | |
| For State Registrar | | State o | of Ma | ryland / Depa <i>Cer</i> | artment of H tificate of I | lealth and N Death | | e 2e) (| 15 | 38271 |
| 1. Decedent's Name | e (First, Middl | e, Last) | | | | | 2. Date of Death | | | 3. Time of Death |
| Thomasi | ne | Elaine | 9 | Rog | pe r- Evar | ıs | Novembe Novembe | r 18. | 2005 | 4:28 a. ^M |
| 4a. Facility Name (/ | f not institution | n, give street and nu | mber) | | 4b. City, Town, or | Location of Death | | 4c. Count | y of Death | |
| Sinai Hos | spital | Emergency | Roo | om | Baltim | ore | | | | |
| 5. Social Security N | umber | 6. Sex | 7. Age | (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 4 | 9. Birthp | lace (State or Foreign |
| 238-52-9 | 9534 | 1 ☐ M 2 💢 F | | 41 Yrs. | Months Days | Hours Min. | 09 04 | 64 | Cour | CO |
| Usual Residence of | Decedent | | | | | | 1 | | 4 | |
| 10a. State | 10b. County | | | 10c. City, Town or Lo | cation | | | | 1 | 0d. Inside City Limits |
| MD | NA | A | | Baltimo | re | | | | | 1 X No 2 □ No |
| 10e. Street and Nur | mber | | | | 10f. Zip Code | | 10 | g. Citizen of | What Cour | ntry? |
| 2111 Gai | rrisor | n Blvd A | pt | 207 | 212 | 216 | | U. | S.A. | |

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility March F/H West

1 Yes 2 XNo

16a. Decedent's Usual Occupation

Unemployed

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glennview

23a. yart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence

Race - American Indian, Black, White, etc.

Black

21215

Approximate Interval Between Onset and Death

Specify:

18. Mother's Name (First, Middle, Maiden Surname) Hazel Lillie Lunford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5603 Kemmont Drive, Durham, NC 27713

Date

11/26/05

4300 Wabash Ave, Baltimore, Md

16b. Kind of Business/Industry

Unemployed

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of

206

2 No

3 Probably

Yes

Year

4 Unknown

21215

Month

Durham, NC

death with the Maryland 7 is marked other then "naturel", or items 23a or 28e-f show traumatic event, it a Medical Examinational training at permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Insportent: If Item 27 is marked other than "naturel", or the eny injury or other traumatic event. It a Medical Examinat once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

be executed burial-transit Division of Vital Records, P.O. Box 68760. the attending physicien use as the ja ate has been signed by the page 2 should be detached the Hospital or Attending Physician: funeral director, this After t 24 hours after death.

Funerel Director: A

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o. as a consequence of) Examiner Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Onknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes Completed 24a. Was an autopsy performed? es 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2X ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 1 Natural 5 Pending 20/8/05 investigation 1 🗌 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Sp + ify)28f. Location (Street and Number or Rural Route Number City or Town, State) Homicide HOME 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatu certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME November 18, 2005 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 1111 Penn Street Baltimore, Maryland 21201 4 IN

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ZY No If Yes, Give Year or Dates:

College (1-4or 5+)

na

DHMH 17 Rev 1/2001

within 24

ዓ

Registrar

State

31. Date filed (Month, Day, Year)

NOV 2

9 2005

32. Registrar's Signature

| | | | For State Registrar | | State of M | aryland | | | t of H | ealth a | | | 9 | | 382 | 72 |
|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------|--------------|------------------------------|----------------------------------------------------|--------------------------|-----------------------------|------------|------------------------------------|----------------------------------|-------------------------------------|---------------------------------------|------------|
| | Physic | | 1. Decedent's Name (F | First, Middle, Last) | RUFF | = | | | | | | 2. Date of Dea Month | th Day &t | Year 2005 | 3. Time o | Death |
| > | /Medi Exami | | 4a. Facility Name (If no | t institution, give | | | | 4b. City. | Town, or | Location of | | 100 21113 | 4c. Count | | 12- | |
| | Exami | | Northwes | t Hospit | al Center | _ | | | | 1stow | | | | imore | | |
| | Funeral | | 5. Social Security Numb | ber 6. Sex | 7. Ag | | ast birthday) | If Under Months | | If Under 2 | | 8. Date of Birth (Month, Day | Year | 9. Birthp | ace (State o | or Foreign |
| | Director | | 063-30-34 | 49 | M 2□F | 69 | Yrs. | WOTH | Days | Tiodis | | ruary 2 | | | | |
| | land | | Usual Residence of Dec 10a. State 10 | b. County | | 10c. City, | , Town or Lo | cation | | | | | | 1 | Od. Inside C | ity Limite |
| | Mary 1 sh | ţō | MD 1 | Baltimor | e | Rand | la11st | own | | | | | | | | 2 🖵 No |
| | h the | irec | 10e. Street and Number | r | | 1 | | 10f. Zip | Code | | | | 0g. Citizen of | What Coun | | |
| 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If items 27 is marked other than "naturel", or items 23a or 28e-f show or other traumatic event, the Medical Evaria at must be rediffed at | Completed by Funeral Director | 5412 O1d 11. Marital Status 1 Never Married 3 Widowed 4 | 2 Married Divorced Decedent's Educ | 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | | 16a. Deced | Was Deced f Yes, spec 1 Yes 2 dent's Usua | l Occupat | Specify: | | ify Yes or No- ican, etc.) | Bta | ce - Americ ck, White, e Whit | an Indian, etc. te | rica |
| 21 | thin 7 e. | Jple | Elementary/Secondar | only highest grade ry (0-12) | College (1-4or 5 | i+) | (Give life. L | kind of wor DO NOT us | k done du e retired) | uring most o | of working | 7 | | | , | |
| 2 | 12 should be filed within hand Mental Hygiene. 7 Is marked other than "raumatic event, the Me. | Con | 12 | | 0 | | Man | ager | | | | | Pharma | ceuti | ca1s | |
| nd | be fill d off | Be | 17. Father's Name (Firs | | | | | | | 18. Mother | s Name (| First, Middle, I | Maiden Suman | ne) | | |
| Z la | ould Men narke | 2 | | Ruff | | | | | | Anna | | alters | | | | |
| Maryland | d 2 st th and 7 Is r traun | | 19a. Informant's Name | Helationship (<i>Ty)</i> aniel | | | | | | | | Route Number | | | Code) | |
| | 1 and Health tem 27 | | 20a. Method of Disposit | | 17.1 | | 04 H1 | | | enue, | Oran | ngeburg | , N. Y. | | | |
| υ | Pages nent of I int: If it | | 1 ₩Burial 2 ☐ Cr | remation 3 🗆 R | emoval from State | cer | metery, cren | natory or oth | her place, | · 1 | | | | | | |
| Baltimore, | + E E = . | 1 6 | 21. Signature of Funera | | 90 | Lake | View | Memo: | rial | Pk] | 11/28 | 3/05 S | ykesvi] | lle, M | aryla | nd |
| ä | Depa Impo eny it | 1, 17 | 1/2/ | (e) | | | \$7 | 28 T 1 1 | horts | T. Poo | LOT1 | ng Byer andalls | s Funei | al Di | recto | rs |
| | Physician /Medical Examiner | her | Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediates. | ons, diate | e cause on each iif Due to (or as | a conseque | ence of): NEU | SE 1 MO | PSI | S | ardiac or | respiratory arr | est, | | Approximate Interval Bett Onset and [| ween |
| x 68760, | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit | Physiclan/Medical Examiner | Cause (Disease of Information Information Information Information Information Information Information Information Information Information Information Information Information Information Information Information Information | o d | Due to (or as | | | | | | | | | | | |
| P.O. Box | it the death of by the atten- tached for us | hysiclan | 23b. Was decedent pre in the past 12 mon 1 Yes 2 No 9 Unknown | iths? | 3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal d | teath 3 🗆 | Ectopic pre Other (spe | | | | | 23d. Dai | e of deliver nth [| | fear |
| ທົ | w requires that been signed I should be det | by | Part II. Other significan | MELL | LITUS | PRO | STAT | EX | CNA |) | | | acco use cont | | | |
| of Vital Record | e law re has be je 2 shc | Completed | BLADNER | C2120 | INOMA | , (| COR | ONAR | 24 | ART | Eny | 24a. Was ar | | Vere autop | sy findings a | available |
| - B | Thate are pag | Con | DISEASE | | | | | | | | | perform | red? c | leath? | Dietion of Ca □ No | luse or |
| /ita | certifica rector, p | Be (| 25. Was case referred to examiner? | | | | | | 2 | 26. Place of | f Death (| Check only one | | | | |
| of | hys this aldi | 2 | 1 Yes 2 No | H | ospital: | | R/Outpatient | | | 4 Nursi | ing Home | 5 Reside | nce 6 Oth | er (Specify) | | |
|) N | ling After Tune | lon | | Pending | 28a. Date of Injur (Month, Day | Year) 2 | 8b. Time of Injury | | c. Injury a Work? | | | d. Describe ho | w injury occurr | ed | | |
| Division | or Attending after death. Director: After din by the funer | Certification: | 2 Accident 3 Suicide 6 | investigation Could not be | 28e. Place of Inju | Inv. At hom | a farm stra | M . | | s 2 □No | | Location /Ct | and and bloom | | G | |
| Θ | in the second | ertii | 4 🗌 Homicide | determined | building, etc | . (Specify) | io, iaini, sile | et, ractory, | OHICO | | 201 | Location (Str City or Town | State) | er or Hural | HOUTO NUME | er, |
| | ospite hours unerel | edical C | 29a. Certifier 1 (Check only one) | Certifying Physi Medical Examin | ician: To the best of er: On the basis of and manner sta | examinatio | edge, death in and/or inv | occurred at estigation, in | t the time, n my opin | , date and p nion, death | olace, and | d due to the ca at the time, da | use(s) and ma te and place, a | nner as sta ind due to t | ed. he cause(s) | |
| | To the H within 24 To the Fi | N | 29b. Signature and title | | | | | 1 — | License r | | | 29 | d. Date signed | (Month, D | ay, Year | |
| | de | | PK R | niger | rogth | 1 | 4D | |)5 | 428 | 8 | 1 | d. Date signed | ber ? | 2102 | 005 |
| <i>j</i> | 3 | | 30. Name and address of ANIASI | VANIY | TOA | V CIA | 2000 | Print) | No | RTHWI | 357 | Hospi | TAL C | ENTE | 12 | |
| | Sta Registr | | 31. Date filed (Month, Da NOV | ay, Year) 2 9 2005 | 32. Registra | r's Signatur | TO ADDA | w | | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| 3 | 8 | 2 | 7 | - |
|---------|---|-----|-----|---|
| \circ | V | E.w | - 8 | • |

| | 1 = For State Registrar |
|-------------------|-------------------------|
| | 1. Decedent's |
| hysician /Medical | |

| Physici | ian | Decedent's Name (First, Middle, Last) | | 2. Date of De | nath Day Yeer | 3. Time of Death | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------|--|--|--|--|--|--|
| Physici /Medio | | Audrey T. Rivers | | Novembe | r 17, 2005 | 7:55 A. ^M | | | | | | |
| Examir | ner | 4a. Facility Name (If not institution, give street and number) | | or Location of Death | 4c. County of Death | | | | | | | |
| | | Fairfield Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birtha | Crownsv | | Anne Arun | | | | | | | |
| Funeral Director | | 219-16-3895 1 M 2 K 83 Yrs | Months Days | Hours Min. (Month, Da April 10 | ly, Year) Co. | hplace (State or Foreigr untry) yland | | | | | | |
| ow I | | 10a. State 10b. County 10c. City, Town o | or Location | | | 10d. Inside City Limits | | | | | | |
| Mary P-f sh | to | MD Talbot Easton | Į. | | | 1 ☐ Yes 2 ☐ No | | | | | | |
| or 286 | irec | 10e. Street and Number | 10f. Zip Code | | 10g. Citizen of What Co | | | | | | | |
| 23a c | aiD | 29389 Woodridge Drive | 216 | 01 Un | ited States | of America | | | | | | |
| ar dae | Funeral Director | Armed Forces? | Was Decedent of H If Yes, specify Cubi | Hispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.) | 14. Race - Amer Black, White | | | | | | | |
| parmit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Haatib and Mantel Hygiena. Department: If term 27 is merked other than "natural", or itama 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be inclined at once. | by | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: | 1□ Yes 2∏ No | Specify: | Specify: Wh | ite | | | | | | |
| "natur | Completed | 15. Decedent's Education 16a. De (Specify only highest grade completed) (G | ecedent's Usual Occup Give kind of work done | pation during most of working d) | 16b. Kind of Business/l | ndustry | | | | | | |
| withir ans. than than | ошо | Elementary/Secondary (0-12) College (1-4or 5+) | Sales Rep | | Trophy | | | | | | | |
| filad Hygi other | 0 | 17. Father's Name (First, Middle, Last) | July 110 | 18. Mother's Name (First, Middle, | | | | | | | | |
| uld be tental rkad ric ev | To B | Brainard Todd Briel | | Eleanor Wilhemi | na Maguire | | | | | | | |
| shou and M smar | - | 19a. Informant's Name/Relationship (Type, Print) 19b. M | Mailing Address (Street | and Number or Rural Route Numb | er, City or Town, State, Z | ip Code) | | | | | | |
| and 2 aalth n 27 i | | Ms Peggy Ferguson (Daughter) 293 | 89 Woodrid | ge Drive, Easton | . Maryland | 21601 | | | | | | |
| and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t | | 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State | isposition (Name of crematory or other plac | ce) Date | 20c. Location - City or 1 | Town, State | | | | | | |
| r Pag tment tant: jury o | | '4 □Donation 5 □Other (Specify) Woodlay | wn Cemetery | | Woodlawn, Ma | | | | | | | |
| armit papari npor ny in | | 21. Signatore of Funeral Service Licensee | 22. Name and Addre | ess of Facility Loring By | ers Funeral | Directors, | | | | | | |
| 403 40 | | | | ty Road, Randall | | | | | | | | |
| | | 23a. Pa 6 /l. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. | enter the mode of dyin | ng, such as cardiac or respiratory a | rest, | Approximate Interval Between Onset and Death | | | | | | |
| Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Chromogolie (Final disease or condition a. Chromogolie (Final disease)) | Thy | | | | | | | | | |
| Examiner | | Due to (or as a consequence of): | | ^ | | | | | | | | |
| | -er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of): | | | | | | | | | | |
| utad 1 ansit | Examiner | cause. Enter Undertying Cause (Disease or injury that initiated events c. | | | | | | | | | | |
| ba axacutad sician and burial-fransit | Exa | resulting in death) Last Due to (or as a consequence of): | : | | | | | | | | | |
| cate ba physicia tha bu | icai | d | | | | | | | | | | |
| ath certificate ba executed tranding physician and or use as the burial-fransit | an/Medical | IF FEMALE: | | | | | | | | | | |
| ath certifi attanding for use as | an/I | 23b. Was decedent pregnant in the past 12 months? | 3 ☐ Ectopic pregnancy | у | 23d. Date of deliver Month | very Day Year | | | | | | |
| at the dea | Physici | 1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown | 5 Other (specify) | | Mortur | Day Feat | | | | | | |
| Tha law requires that the deate has been signed by the abage 2 should be detached to | Phy | Part II. Other significant conditions contributing to death but not resulting in the | ne undertying cause giv | ven in Part I 23e. Did to | obacco use contribute to | the cause of death? | | | | | | |
| signe d ba | Completed by | Dementy. Failure to thrive | io andonying dadad giv | | | bably 4 Unknown | | | | | | |
| w requires been sign should be | etec | orner an, man a more | | | | | | | | | | |
| has has | mpi | | | 24a. Was autor | osy prior to death? | topsy findings available ompletion of cause of | | | | | | |
| | e Co | OF Western State of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state o | | 1 ☐ Yes | 2 ☑ No 1 ☐ Yes | 2 2 No | | | | | | |
| sicia s carti iracto | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa | atient 3 DOA Oth | 26. Place of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (Check onl | | (6.1) | | | | | | |
| a Phy arthis arald | - | 27. Manner of Death 28a. Date of Injury 28b. Tim | ne of 28c. Injur | v at 28d. Describe I | now injury occurred | iry) | | | | | | |
| nding ath. r: Aft | atio | 1 ☑Natural 5 □ Pending (Month, Öay Year) Inju 2 □ Accident investigation | | Yes 2 No | | | | | | | | |
| Atts ecto by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | , street, factory, office | 28f. Location (S City or Tov | Street and Number or Rui | ral Route Number, | | | | | | |
| tal or rs afte al Dir | Cerl | Building, cit. (aposity) | | Ony or 100 | m, olato) | | | | | | | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this cartifica completely filled in by the funaral director, | Medicai | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Exeminer: On the basis of examination and/o and manner stated. | leath occurred at the tin or investigation, in my o | me, date and place, and due to the opinion, death occurred at the time, | cause(s) and manner as date and place, and due | stated. to the cause(s) | | | | | | |
| To the within To the Comp | Me | 29b. Signature and title of perifier | 29c. Licens | | 29d. Date signed (Month, | | | | | | | |
| 6 | | M MD | ₩ 3 | 8958 | 11/17/0: | 5- | | | | | | |
| - | | 30. Name and address of person who completed cause of death (Item 23a) (Ty | rpe, Print) | 1 | | | | | | | | |
| | | Daljeet Singh Sille 208 C | rain Hyl | Lway S.W GE | En Burnie | MD21061 | | | | | | |
| Sta | | 31. Date tiled (Month, Day, Yeak) 32. Begistrar's Signature | Anaste & | \bigvee | | | | | | | | |
| Regist | | 30. Name and address of person who completed cause of death (Item 23a) (Ty Da Leet Sing Sium 2-08 31. Date filed (Month, Day, Yeak) 32. Registrar's Signature | | | | | | | | | | |
| 1H 17 Rev 1/2 | 001 | | | | | | | | | | | |

| | | | 1 - For State Registrar | State of M | laryland | | artmen rtificate | | | | | Reg. No. | 5 3 | 38274 |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------|------------------------------------|-----------------------------------------|---------------|--------------------------|--------------------|-------------------|-----------------|-------------------------------------------|---------------------------------------|-------------------------|---------------------------------------------|
| | Physici | | 1. Decedent's Name (First, Middle, La | 181816 | | | | | | | 2. Date of Dea | Day | Year | 3. Time of Death |
| | /Medio Examir | | 4a. Fecility Name (If not institution, gi | |) | | 4b. City, | Town, or | Location | of Death | | 4c. County | | |
| | | | JEWISH CONVALE | | | | | | MORE | | | | ALTI | |
| | Funeral Director | | 219-18-8159 | Sex 7. A 1 | ge (In yrs. Ias | Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Da FEB . 19 | , 1924 | 9. Birthp | lace (State or Foreign try) MD |
| | and w | | Usual Residence of Decedent 10a, State 10b, County | | 10c. City, | Town or Lo | cation | | | | | | 1 | 0d. Inside City Limits |
| | Marylan f show led at | ō | MD N/ | Δ | | RAI | TIMOR | E | | | | | | 1 X Yes 2 ☐ No |
| | 1 the | rec | 10e. Street and Number | | | J. 12 | 10f. Zip | | | | | 10g. Citizen of V | /hat Cour | ntry? |
| | h with | Funeral Director | 2901 FALLSTAFF | ROAD #20 | 3 | | | | 212 | 209 | | | | USA |
| | деат этта | ner | 11. Marital Status | 12. Was Deceden Armed Forces | t Ever in U.S. | . 13. | Was Deced | lent of Hi | spanic Ori | igin? (Sp | ecify Yes or No Rican, etc.) | 14. Race | e - Americ k, White, | an Indian, |
| 36 | within 72 hours after death with the Maryland ane. than 'natural', or Itema 23a or 28a-f show ha Madical Examinar must be indiffed at | by Fu | 1 ☐ Never Married 2() Married | 1 XYes 2 I | No WWI | T | 1 ☐ Yes | | Specify: | | | Specify | | WHITE |
| Ö | hour: | q pe | 3 Widowed 4 Divorced | Year or Dates: | | 16a Dece | dent's Usua | I Occups | ation | | 1 | 16b, Kind of Bu | siness/Inc | |
| 15 | in 72 in 72 | plete | (Specify only highest gi | rade completed) | | (Give | kind of wor DO NOT us | rk done a | <i>luring</i> mos | t of work | ing | TOD: KING OF DO | 3111033/1110 | austry |
| 21215-0036 | yiene. | Completed | Elementary/Secondary (0-12) | College (1-4or 2 | 5+) | SALE | SMAN | | | | | APPLIA | NCES | |
| | be filed ital Hygie of other | Bec | 17. Father's Name (First, Middle, Las | t) | | | | | | | e (First, Middle, | Maiden Sumam | ө) | |
| ylaı | should b | To | LOUIS | | | REIS | | | | NNIE | | | | KAUFMAN |
| Maryland | C/ c0 = 00 | | 19a. Informant's Name/Relationship | | | | - | | | | | or, City or Town, BALTIMOR | | |
| | 1 and Health em 27 ther tr | | MILDRED REISIG | WIFE | 20b. Pla | | sition (Nan | | | | Date | 20c. Location - | | |
| nor | Pages nent of int: If it | | 1 X Burial 2 Cremation 3 | | 9 | | | | , | E1 1' | 1/28/05 | | | E, MD |
| Baltimore, | artme ortani injury | | * 4 □ Donation 5 □ Other (Spec 21. Sig of re a Funeral Service List | 7 / | MITK | | 2. Name an | | | | - | INSON & | | |
| Ba | permit. Departr Importa any inju | | & Millerall | Dug | 21. | 4 | 8900 | RFI | STERS | | | | | , MD 21208 |
| | | | 23a. Part1. Enter the disease, or cor shock, or heart failure. List only | nplications that ause | od the death. | Do not en | | | | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | an Le | 40 | eman | tis | | | | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or a | s a conseque | ence of): | CATIVE | | | | | · · · · · · · · · · · · · · · · · · · | | |
| | Examiner | _ | Sequentially list conditions, | b. En | s a conseque L Sta s a conseque | ge | chron | ici | Heart | Po | dure | | | |
| | ed sit | Examiner | cause. Enter Underlying Cause (Disease or injury | Due to for a | s a conseque | ep e or): | | | | U | | | | |
| | xecut and al-trar | xan | that initiated events resulting in death) Last | c. Due to (or a | s a conseque | ince of): | | _ | | | | | - | |
| 8760, | icate be executed physician and s the burial-transit | icai | | d | | | | | | | | | | |
| 9 | g phy as the | ed | | <u>.</u> | | | | | | | | | | |
| Вох | eath certific attending pl | M/ug | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | | Ectopic pr | egnancy | | | | | e of delive | |
| | s deat he att | sicis | in the past 12 months? 1 □ Yes 2 □ No | 4□Pregnant | | | Other (sp | | | | | Mor | ntn | Day Year |
| P.0 | res that the de signed by the a be detached f | Physician/M | 9 Unknown Part II. Other significent conditions | contribution to death | but not result | ting in the u | adach ina a | 21100 224 | on in Bart I | | 23a Did to | phacen use contr | ibute to th | ne cause of death? |
| S, | requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit | l by | Part II. Other significent conditions | contributing to death | Dat not result | ing in the d | riderlying c | ause give | on in Fait i | | 1 🗆 1 | | 3 ☐ Prob | |
| ecords, | w require been si should l | etec | | | | | | | | | 24a. Was | - | Mara auta | con findings available |
| Rec | has has | Completed | | | | | | | | | autop perfo | rmed? | leath? | psy findings available mpletion of cause of |
| a | icien: Th certificate rector, pag | e Co | 25. Was case referred to medical | | | | | | 26 Place | n of Deat | 1 ☐ Yes h (Check only o | | Yes | 2□ No |
| of Vital | Physicien: this certific ral director, | To B | examiner? | Hospital: 1 ☐ Inpat | tient 2 E | R/Outpatie | nt 3 DC | Othe | ar _/ | ursing Ho | | dence 6 Othe | er (Specifi | y) |
| 10 | | | 27. Manner of Death | 28a. Date of In | jury 2 | 28b. Time o | | 8c. Injury Work | 4440 | - | | now injury occurr | ed | |
| ior | Attending r death. ector: After by the fune | atic | 2 ☐ Accident investigati | on | | | М | | Yes 2□ | No | | | | |
| Division | or Att | Certification: | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | 286. Place of I | njury - At hom etc. <i>(Specify)</i> | ne, farm, st | reet, factory | , office | | | 28f. Location (S City or Tox | Street and Numbern, State) | er or Rura | I Route Number, |
| | hours a | i Ce | 29a, Certifier 1 Certifying F | Physician: To the bes | at of my know | ledge deal | h occurred | at the tim | ne date ar | nd place | and due to the | cause/s) and ma | nner as el | tated |
| | e Hos 24 hc e Fun letely | edical | (Check only 2 Medical Exe | miner: On the basis and manner: | of examination | on and/or in | vestigation | , in my or | pinion, dea | ath occur | red at the time, | date and place, a | ind due to | the cause(s) |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Me | 29b. Signature and title of certifier | | | | | | number | | | 29d. Date signed | | Day, Year) |
| | | | > Elovary | si'Gth' | | | | D6 | 317 | 4 | | 11/26 | 105 | |
| | 6 | | 30. Name and address of person wh | | death (Item 2 | 23a) (Type, | Print) | | | | (1. | Ð | | |
| | | | Brahim Flour | ardighi | JEW. | 115/ | PA | DUC | 1630 | ient | t CT. | bal | TM | ore, MI) |
| | St Regist | ate rar | 31. Date filed (Month, Day, Year) | 100 | trar's Signatu | * A | parke | • | | | | | | ore, MD |

State of Maryland / Department of Health and Mental Hygier () 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day ARAH 240 A M NOVENBER 28 2005 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner HOPKINS Ohn cial Security Number 6. Sex 9. Birthplace (State or Foreign Country)
DETTOIT, MI 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 € F Days 522.44-5883 73 Hours Yrs. Director JAN. 26, 1932 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at 10d. Inside City Limits 1 les 2 No by Funeral Director nalewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4165 USA 80110 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: White. 3 Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Mg Elementary/Secondary (0-12) College (1-4or 5+) homemake own nomo 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Hauden 19a. Inform int's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 Is any injury or other trac 20c. Location - City or Town, State Mountainsides Mo -aaughter Date Lolorado Spring 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Evans Funcial Chapel-Belfir 11-30 -05 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility BALTIMORE, MD 21234. Kupota EVANSTUNELAL CHAPEL, 8800 HARF DRD RP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only due cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FUNGAL PHEUMONIA MONTH /Medical Due to (or as a consequence of): Examiner MYELODYSP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine cate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 21X1Vo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 🗀 Pending Injury М 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058475 PHYSICIAN/FELLOW NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIPUIUATPUNIN 1650 ORLEANS STREET CRB 186 BAUTIMORE, MD 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

| | | | For State Registrar | State of Mary | | epartment of learning of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control | | | jiene 0 0 | 5 38276 |
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| | Physici /Medic | | 1. Decedent's Name (First, Middle, L Francis Eugen | 5 . 11 | | | | 2. Date of Dea Month | th Day | Yeer 6:07 P M |
| | Examir | | 4a. Facility Name (If not institution, gi SAINT AGNES H | OSPITAL | | BALTI | or Location of Death MORE | | 4c. County o | 1 4 |
| | Funeral Director | | 5. Social Security Number 6. 215 · 28 · 2343 Usual Residence of Decedent | Sex 7. Age (III | 74 Yrs | Months Days | | 8. Date of Birth (Month, Day 10. 29 | M31 | 9. Birthplace (State or Foreign Country) |
| | death with the Maryland me 23a or 28a-f ehow | tor | 10a. State 10b. County | imbre 10 | Oc. City, Town o | altimore | J | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑No |
| | th with the 23a or 28d | Funeral Director | 10e. Street and Number 1016 Lakemor | it Road | | 10f. Zip Code | 1228 | 1 | 10g. Citizen of WI | hat Country? |
| 36 | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a Mastical Extentional to mail be notified at | by | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Eve Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: | or in U.S. | Was Decedent of If Yes, specify Cut Yes 2 Pro | oan, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | - American Indian, , White, etc. Black |
| Baltimore, Maryland 21215-0036 | within 72 hou ene. than "neture he Mevical E | Completed | 15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) | Education rade completed) College (1-4or 5+) | (0 | ecedent's Usual Occu Give kind of work done to. DO NOT use retire | during most of work ed) | | 16b. Kind of Bus | |
| and 21 | ube filed wat Hygier ed other the | Be | 12th grade 17. Father's Name (First, Middle, Las Clarles E S | N/A | 3 | shipyara | 18. Mother's Name | | Maiden Sumame | |
| Mary | nd 2 should alth and Men 27 is marke ir traumatic | 10 | 19a. Informant's Name/Relationship Sallie O. Smil | 17 / 19 | | Mailing Address (Stree | t and Number or Run | al Route Number | } | D 21228 |
| imore, | permit. Pages 1 and 2 s Department of Health at Importent: If Itam 27 is eny Injury or other trau 2005. | | 20a. Method of Disposition 1 SBBurial 2 Cremation 3 4 Donation 5 Other (Spec | Removal from State | 20b. Place of D cemetery, | isposition (Name of crematory or other pla | 11.3 | Date 0 . 05 | 20c. Location - C | City or Town, State |
| Balti | permit. Departn Importe eny Injt | | 21. Signature of Funeral Service Lice | ensee 21 | | 22 Name and Addr Vaugus 515 VBal | ess of Facility C. Greene timbre Na | funero | al Servi Dike Bal | ito. MD 21229 |
| | Physician /Medical Examiner | ıer | 23a. Part1. Enter the disease, or coshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | y one cause on each line. | RDIAL onsequence of) | - JNFA | ing, such as cardiac | | est, | Approximate Interval Between Onset and Death UNKNOWA |
| E 8760, < | icate be executed physicien and sthe burial-transit | dical Examiner | cause, Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a co | onsequence of) | : | | | | |
| RANCIS | The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as: | Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown | Fetaf death | 3 □Ectopic pregnand 5 □ Other (specify) | су | | 23d. Date Mont | of delivery th Day Year |
| FRH rds, P | w requires that been signed b should be deta | ed by P | Part II. Other significant conditions CONGESTIV | | | | iven in Part I. | | | bute to the cause of death? 3 Probably Unknown |
| SMITH Vital Reco | | Complet | | | | | | 24a. Was a autops perform | media de | lere autopsy findings available for to completion of cause of eath? Yes 2 No |
| S M of Vita | Physician: Th this certificate al director, pag | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: Inpatient | 2 ER/Outp | | | me 5 Reside | ence 6 □Other | |
| SMITH, FRANCIS Division of Vital Records, P.O. Box | Jing P | Certification: | 27. Manner of Death Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine | be 390 Phase of Initial | - At home, farm | ary Wo |]Yes 2 □No | | | r or Rural Route Number, |
| | To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the | Medical C | 29a. Certifier (Check only one) Certifying I 2 Medicaf Ex | Physician: To the best of maminer: On the basis of ex and manner stated | amination and/ | death occurred at the tor investigation, in my | time, date and place, opinion, death occur | and due to the cred at the time, d | ause(s) and man late and place, ar | ner as stated. nd due to the cause(s) |
| | To the within 2 To the complete | W | 29b. Signature and title of certifier | le | M.D | | 86)6. | | _ | (Month, Day, Year) 15 2005 |
| | 4 | | 30. Name and address of person who PRIYAN KA NE 31. Date fifed (Month, Day, Year) | completed cause of death | | ype, Print) H CATON | V AVENI | JE, BA | LTIMO | RE, MD-2,1229 |
| | Pegist | ate | MOV 9 A 28 | | to A | 1000 | | | | |

DHMH 17 Rev 1/2001

| | | | | For State Registrar | State of N | Maryland / | - | | f Health and of Death | Mental Hy | ygiene Rog. No. | 15 | 38277 |
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| | | Physici | an | 1. Decedent's Name (First, Middle, La | | | | | | 2. Date of D Month | eath Day | Year | 3. Time of Death |
| | | /Medic | al | Howard 4a. Facility Name (If not institution, giv | C. Scot | | | 4b. City. Tow | m, or Location of De | Novem | | 2005 y of Death | 6:00 A ^M |
| | | Examin | ier | Continuum Care of | | | | | esville | | | Carro | ol1 |
| | | Funeral Director | | 5. Social Security Number 6. S 213-60-2738 | ex 7. / M 2□ F | Age (In yrs. last 55 | | If Under 1 You Months Da | ear If Under 24 H ays Hours Mi | 8. Date of B | ^{irth} 1950 | 9. Birthp Cour Mary | place (State or Foreign Tand |
| | | land bw | | Usual Residence of Decedent 10a, State 10b, County | | 10c. City, T | own or Loc | ation | | | | 1 | 0d. Inside City Limits |
| | | Mary B-f sho | tor | Maryland Carrol | .1 | | Sykes | sville | | | | | 1 ☐ Yes 2 No |
| | | ith the | Director | 10e. Street and Number | | | | 10f. Zip Coo | | | 10g. Citizen of | | ntry? |
| 1 | | eath w | eral | 7309 Second Ave | 12. Was Deceder | nt Ever in U.S. | 13. W | as Decedent | 21784 | (Specify Yes or N | US 10- 14. Ra | Ce - Americ | can Indian, |
| N. | 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Itema 23e or 28e-f show important: If Item 27 is marked other then "natural", or Itema 23e or 28e-f show any Injury or other traumatic event, the Medical Expiritive rivust be multiled at once. | by Funeral | 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Force 1 Yes 2 If Yes, Give Year or Date: | s? ∑iNo | | Yes, specify (| of Hispanic Origin? Cuban, Mexican, Pu No Specify: | àrto Rican, etc.) | ľ | ack, White, ity: Whi | |
| Der me | 5-0 | 72 ho | eted | 15. Decedent's E (Specify only highest gra | ducation ade completed) | 1 | 6a. Decede | ent's Usual Or ind of work do | ccupation one during most of w etired) | vorking | 16b. Kind of E | Business/In | dustry |
| 0 | 21215-0036 | within ene. then | Completed | Elementary/Secondary (0-12) | College (1-4d | or 5+) | | ectri | | | Commer | cial | Electric |
| 9 | | e filed Il Hygi other | Be Co | 17. Father's Name (First, Middle, Last | | | | | 1 | ame (First, Middi | · · | me) | |
| 3 | ylar | ould by Menta Merked Marked | ToE | Gordon Mitchell | | | | | | n C. Kir | - | | |
| | Maryland | d 2 sh th and th and traum | | 19a. Informant's Name/Relationship (Debra L. Lyons, | | | - | | reet and Number or ne Road We | | | | |
| 3 | | s 1 an if Heal Item 2 other | | 20a. Method of Disposition | | 20b. Plac | e of Dispos | ition (Name o atory or other | of ! | Date | 20c. Location | | |
| | i i | Page nent o ant: M ury or | | 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont | | 10 | Cren | natory | Inc. 11/ | /28/05 | | , | Maryland |
| | Baltimore, | permit. Departr Imports eny inj | | 21. Signature of Funeral Service Lice Thomas Gregor | Sey- | | Ĉi 29 | ematic 9 Free | dressof Facility derick Roa | of Mary ad Balti | yland In nore, Ma | ıc. ırylan | d 21228 |
| • | | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a | as a consequen | oln | | dying, such as card | iac or respiratory | arrest, | | Approximate Interval Between Onset and Death |
| k | 8760, | cate be executed your scient and the burial-transit | dicai Examiner | S-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | as a consequer | | 3 | | | | | |
| | P.O. Box 6 | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | i 2 ☐ Fetal de t at time of deat | eath 3 🔲 | Ectopic pregn Other <i>(specil</i> | | | | ate of delivi | ery Day Year |
| | | uires that signed b | by | Part II. Other significant conditions | contributing to death | h but not resultir | ng in the un | derlying caus | e given in Part I. | | | | he cause of death? |
| 5 7 | Vital Records, | The law requir ate has been si page 2 should l | Completed | | | | | - | | 24a. We aut per | opsy formed/ | . Were auto prior to co death? 1 Yes | opsy findings available impletion of cause of |
| Z | Vita | ysician: The is certificate hi director, page | Be | 25. Was case referred to medical examiner? | Hospital: | | 120 | | 0 | eath Check only | | | |
| Ka | of | Phys or this oral dir | . To | 1 ☐ Yes 2 ☑ No 27. Manger of Death | 1 ∐ Inpa 28a. Date of I (Month, | atient 2□EF njury 28 | 3b. Time of | | Injury at Work? | Home 5 ☐ Re 28d. Describ | sidence 6 ∐Oi e how injury occu | | (y) |
| B | ion | tending Ph death. tor: After th the funeral | ation | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | on | Day rear) | Injury | М | 1 Yes 2 No | | | | |
| 70 | Division | • Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fu | Certification: | 3 Suicide 6 Could not l 4 Homicide determined | 286. Place of | Injury - At home etc. (Specify) | e, farm, stre | et, factory, of | ffice | 28f. Location City or T | (Street and Numown, State) | nber or Rura | al Route Number, |
| | | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by | edical (| 29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa | hysician: To the be miner: On the basi and manner | s of examination | edge, death n and/or inv | occurred at t estigation, in | he time, date and pla my opinion, death of | ice, and due to the courred at the time | e cause(s) and n e, date and place | nanner as s n, and due t | stated. o the cause(s) |
| _ | | To the To the Comp | Ž | 29b. Signature and Itle of certifier | | | | | cense number | 1 | 29d. Date sign | | |
| | | n | | | 1 | A 4 - 2 1/2 - | 20) (7: | | 205076 | 7 | Novemb | er 28 | , 2005 |
| | | 9 | | 30. Name and address of person who Ernesto Mendoza, | | 1 | | | tminster. | MD 2115 | 7 | | |
| | | St Regist | ate | 31. Date filed (Month, Day, Year) | 32. 19 g | istrar's Signatur | | | | | | | |

| | | | For State Registrar | State of N | /laryland / | | irtment of H | | Mental Hy | gierne () | 05 | 38278 |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------|-------------------------|------------------------------------------------------------------|--------------------------------------------|------------------------------------|----------------------------------|-----------------------------------|---------------------------------------------|
| | Dhusia | | 1. Decedent's Name (First, Middle, | | | | | **** | 2. Date of De | eath Day | Year | 3. Time of Death |
| 5 | Physic /Medi | | Robert Hugh | | | | | | Novemb | per 24, | 2005 | 5:40 A M |
| 7 | Examir | ner | 4a. Facility Name (If not institution, | - | | ļ | • | Location of Death | | | nty of Death | |
| 3 | | | 3331 South Leist | | SLVCL. Age (In yrs. last b | irthdav) | S1 LV6 If Under 1 Year | er Spring | 8 Date of Bi | rth | ontgon | nery place (State or Foreign |
| Ś | Funeral Director | | 195-18-8360 | 1 X M 2□ F | 81 | Yrs. | Months Days | Hours Min. | Apr 1 | .5, 192 | Сош | nsylvania |
| | Р. | | Usual Residence of Decedent | | 100 Cit. To | | | | | | | |
| 5 | show | 2 | 10a. State 10b. County | | 10c. City, To | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| 0 | the Ma 28e-f | ecto | Maryland Mont | gomery | 5: | live | r Spring | | | 10g. Citizen o | of What Cou | |
| 36 | with 3e or | Funeral Director | | Marald F | 171 | | 2090 | 16 | | | SA | , . |
| | after death w | nera | 3331 South Leisi 11. Marital Status | 12. Was Deceder Armed Force | nt Ever in U.S. | 13. \ | Vas Decedent of H | ispanic Origin? (Sr | pecify Yes or No | o- 14. R | ace - Americ | |
| | 036 ours after death with the Maryla rel', or Items 23e or 28e-f shor | F. | 1 Never Married Marrie | od 1X1Yes 2[If Yes, Give | | | □ Yes 2X No | Specify: | nican, etc./ | 1 | lack, White, c <i>ity:</i> Whi | |
| 6 | 1215-0036 within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Modical Examiner must be truitlied at | d by | 3 Widowed 4 Divorced | Year or Dates | | | | | | | | |
| 7/ | 15- in 72 | Completed | 15. Decedent' (Specify only highest | grade completed) | | (Give | lent's Usual Occupa kind of work done o DO NOT use retired | during most of wor | king | 16b. Kind of | Business/in | idustry |
| ジレン | 2121 d within giene. r then | mo. | Elementary/Secondary (0-12) | College (1-4o | or 5+) | S | alesman | | | | Lumbe | er |
| Ī | Ind 21215-0 be filed within 72 ho ltal Hygiene. d other then "netu event, it e Modical | Be C | 17. Father's Name (First, Middle, L | ast) | | | | 18. Mother's Nam | ne (First, Middle | , Maiden Sum | ame) | |
| 5 | Maryland 2. 2 should be filed v and Mental Hygie 1 is marked other i reumatic event, ib | 2 | Hugh Stirling | | | | | Dorot | hy Nich | ol | | |
| , | re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours af Health and Mental Hygiene. Item 27 is marked other then "neturel", or other treumatic event, the Medical Exam | 10.8 | 19a. Informant's Name/Relationsh | | | | | | | | | ^{Code)} 20906 |
| 7 | G, 1 an Heal | 1 4 | Lois S. Stirling 20a. Method of Disposition | ng, Wire | 20b. Place | of Dispo | sition (Name of | | Date DIV | 20c. Location | | ring, MD |
| P | Pages nent of lint: If its | | 1 ☐ Burial 2X☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | 10 | | natory`or other plac ematory I | · 1 | 26/05 | Raltin | noro | Maryland |
| 9 | 事 교육원공 . | 1 | 21. Signature Funeral Service | | 11/ | 22 | . Name and Addres | ss of Facility | | | | |
| 1 | Bal permi Depa Impo | | George E. M | 1acNabb | 120 | 2 2 | remation 99 Freder | Society ick Road | O <u>t</u> Mary Baltin | Land, I | inc. arvlan | d 21228 |
| | | | 23a. Part1. Enter the disease, or o shock, or heart failure. List of | complications that caus only one cause on each | ed the death. Do | not ente | er the mode of dyin | g, such as cardiac | or respiratory a | ırrest, | , | Approximate Interval Between |
| 4 | Physician | 6 1 | Immediate Cause (Final disease or condition | - a ARTER | il oscientar | rie C | madiousco | um oise | ate | | - 4 | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or a | as a consequence | of): | | | | | | |
| | | e e | Sequentially list conditions, | b. Due to [or a | as a cons »quence | of): | | | | | | |
| • | executed in and ital-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | |
| | 8760, 4 ate be executed hysician and the burial-transit | Exa | resulting in death) Last | Due to (or a | as a consequence | of): | | | | | | |
| | 8760, cate be ex ohysician the burial | dical | | d | | | | | | | | |
| | Box 6 eath certific attending p | /Mec | IF FEMALE: | 23c. If yes, outcom | ne of pregnancy | | | | | 224 5 | | |
| | Box (leath certi | clan | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth | 2 Fetal deat | | Ectopic pregnancy Other (specify) | | | | Date of delive Month | Day Year |
| | P.O. that the de detached | hysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | | | | | | | |
| | S, P | Completed by Physiclan/Me | Part II. Other significant condition | N | but not resulting | in the ur | nderlying cause give | en in Part I. | 23e. Did | tobacco use co | ntribute to th | he cause of death? |
| | cords, P w requires that been signed I should be det | ted | Chucinomy or | PROTENTO | | | | | 1 🗆 | Yes 2□No | 3 Prob | pably 4 Minknown |
| | law r law r las be | nple | | | | | | | 24a. Was | nev | prior to cor | psy findings available mpletion of cause of |
| | al Recate has page | | | | | | | | 1 ☐ Yes | ormad? 2 No | death? 1 ☐ Yes | 2□ No |
| | Vital | Be | 25. Was case referred to medical examiner? | Hospital: | | | Othe | 26. Place of Dea | | | | |
| | on of Vital iding Physicien: th. After this certifica | .: To | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 28a, Date of Ir | niury 28b. | Time of | 28c. Injury | er: 4 ☐ Nursing He | | how injury occ | | (y) |
| | ion nding ath. r: Afte | atlor | 1 Natural 5 ☐ Pending 2 ☐ Accident Investig | | Day Year) | Injury | Work | k? Yes 2 ☐ No | | | | |
| | Division of Vital Records, P.O. stor Attending Physicien: The law requires that the darter death. I Director: After this certificate has been signed by the din by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached | Certification: | 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi | 289. Place of | Injury - At home, t etc. (Specify) | farm, stre | et, factory, office | | 28f. Location (City or To | | ber or Rura | al Route Number, |
| | itel or urs aft | | | | | | | | | | | |
| | Division of Vital Records, P.O. Box 6 To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as | edical | 29a. Certifier 1 Certifying (Check only one) | Physician: To the be- examiner: On the basis and manner | of examination a | ge, death ind/or inv | occurred at the time estigation, in my or | ne, date and place, pinion, death occur | and due to the red at the time, | cause(s) and r date and place | nanner as st , and due to | tated. o the cause(s) |
| | o the rithin 2 or the omple | Med | 29b. Signature and title of certifier | and mariner | Stateg. | | 29c. License | e number | | 29d. Date sign | ned (Month, | Day, Year) |
| | F S F Ö | | • | mo | | | 015 | 231 | | 11/2 | 5/05 | |
| | 4 | | 30. Name and address of person v | | f death (Item 23a) | (Type, | 2-1-0 | | IM-D O | 2550 | P | |
| | :== | | CHARL E. WAS | | | | ile giks | Marcine | 4.40 | ~ 44. | | |
| | St Regist | ate trar | 31. Date filed (Month, Day, Year) | 9 2005 32. Resid | due b | 4 | berte | | | | | |

| | | 1- For Amend Item Registrar | 29ataperf Marylan DVR, 11 | 7d / Dep 7 29/05 d | artment of H | lealth and i Death | Mental Hy | giene () (| 38279 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------|-----------------------------------------|-------------------------------------|------------------------------------|----------------------------------------------------------|
| Physic | ian | Decedent's Name (First, Middle, L. | ast) | | | | 2. Date of De. Month | Day | 3. Time of Death |
| /Med | ical | | mpson, 5 | ۱۲. | | | | er 23, 2 | |
| Exami | ner | 4a. Facility Name (If not institution, g 9208 Allensw | 1 _ 1 | | Rando | Location of Death | | Bal | timore |
| Funeral Director | | 5. Social Security Number 6. 217-26-7443 Usual Residence of Decedent | Sex 1 M 2 F 7. Age (In yrs | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bird (Month, Da | th y, Year) /1930 | 9. Birthplace (State or Foreign Country) Maryland |
| land ow | | 10a. State 10b. County | 10c. C | ity, Town or Lo | ocation | | | - | 10d. Inside City Limits |
| Many a-f sh | tor | Md. Baltin | nore R | anda | listown | | | | 1 □Yes 2 No |
| th the or 284 | lrec | 10e. Street and Number | | Di Fi Ca CC | 10f, Zip Code | | | 10g. Citizen of | What Country? |
| 23a 23a | rai | 9208 Allenswo | od Kd. | | 2113 | 3 | | us | A |
| ter de: | Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | | 150 | Was Decedent of H If Yes, specify Cuba | ispanic Origin? (S n, Mexican, Puert | pecify Yes or No o Rican, etc.) | | e - American Indian, ck, White, etc. |
| ours al | þ | 3 ▼ Widowed 4 □ Divorced | If Yes, Give Year or Dates: | 152 | 1□Yes 2XNo | Specify: | | Specif | Black |
| 72 h | etec | 15. Decedent's (Specify only highest g | | 16a. Dece (Give | dent's Usual Occupa kind of work done of DO NOT use retired | ation during most of wor | rking | 16b. Kind of B | usiness/Industry |
| parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or Itams 23a or 28a-f show any Injury or other treumatic event, Ita Modical Examinational be multipled at any Dice. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | 1 | stodia | | | Jani | tor |
| 2 should be filed with and Mental Hygiene. Is marked other than eumatic evant, Ire | Be | 17. Father's Name (First, Middle, Las | | | | 18. Mother's Nan | ne (First, Middle, | | * |
| y Mondal Men narke | To | | pson, Sr. | 101 11 | 100 | Racha | | nder | |
| d 2 st th and th and treum | | 19a. Informant's Name/Relationship | 1 = | | ng Address (Street | | | | State, Zip Code) |
| parmit. Pages 1 and Jopanmit. Pages 1 and Jopanment of Health Importent: If item 27 any Injury or other tronce. | | Nevin Dimps 20a. Method of Disposition | 20b. | Place of UISPO | 6 Queens | - : | Date | 20c. Location | City or Town, State |
| Pages nent of I | | 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec | I Removal from State | | ational Cem | · 1 | /30/2005 | Catons | ille, Md. |
| mit f porter | | 21. Squature of Funeral Service Lic | | | 2. Name and Addres | s of Facility | he Derri | ck C.J | ones F/H, P.A. |
| parmit. Depart Import any Inj | | Kuch | C. | Ч | 611 Park 1 | | | | Maryland 21215 |
| Physician | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition | implications that caused the dealer by one cause on each line. | th. Do not ent | | g, such as cardiac | or respiratory ar | rrest, | Approximate Interval Between Onset and Death |
| /Medical Examiner | | resulting in death) | Due to (or as a conse | | 70000 | 0 | y - vice | | |
| | | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a conse | quence of): | | | | | |
| uted d ansit | Examiner | cause. Enter Underlying Cause (Diseese or injury that initiated events | | | | | | | |
| an an | | resulting in death) Last | Due to (or as a conse | quence of): | | - | - | | |
| icate ba exacuted physician and the burial-transit | dicai | • | d | | | | | | |
| | a a | IF FEMALE: | One If we entreme of comm | | | | | | |
| ath cattend | lan/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregn 1 Live birth 2 Fet | al death 3 | Ectopic pregnancy | | | | te of delivery inth Day Year |
| w requires that the de been signed by the s | Physician/M | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4☐Pregnant at time of 9☐Unknown | beath 5L | Other (specify) | | | | |
| that hed by deta | by Ph | Part II. Other significant conditions | contributing to death but not re- | sulting in the u | nderlying cause give | en in Part I. | 23e. Did to | obacco use cont | ribute to the cause of death? |
| quires in sign | | typer | lensin | | | | 101 | res 2□No | 3 Probably 4 Unknown |
| aw rea | Completed | En | Shysom | | | | 24a. Was | | Were autopsy findings available |
| The lav | mo | Can | con one 6 | 2 ste | le. | | | rmed? | prior to completion of cause of death? 1 □ Yes 2 2 No |
| ien: artifica ctor, p | Be C | 25. Was case referred to medical examiner? | | C08/- | | 26. Place of Dea | th (Check only o | | |
| hysic his ce | 10 | 1 ☐ Yes 2 ☐ No | Hospital: 1 Inpatient 2 | ER/Outpatien | it 3 DOA Othe | er: 4 🗆 Nursing H | ome Resid | dence 6 Oth | er (Specify) |
| or Attending Physicien: The later death. Director: After this certificate his in by the funeral director, page | on: | 27. Manner of Death 102 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | Work | | 28d. Describe h | now injury occur | red |
| ttend death tor: / | cat | 2 Accident investigati 3 Suicide 6 Could not | be 200 Blood of Lainer, At h | ama farm str | | fes 2 □No | 204 Loanties (6 | Stroot and Numb | or or Burni Bouto Mumbos |
| after after I Direct | Certification: | 4 Homicide determine | 28e. Place of Injury - At h building, etc. (Speci | fy) | eet, ractory, office | | City or Tox | | er or Rural Route Number, |
| To the Hospital or Attending Physicien: The law requires that the death cardit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical C | 29a. Certifier Certifying F (Check only one) 2 Medicel Exe | Physician: To the best of my kn aminer: On the basis of examin and manner stated | owledge, death ation and/or in | n occurred at the time vestigation, in my op | e, date and place pinion, death occu | , and due to the orred at the time, | cause(s) and ma date and place, | anner as stated. and due to the cause(s) |
| To th within To th | Me | 29b. Signature and title of certifier | - | | 29c. License | | | 29d. Date signe | d (Month, Day, Year) |
| | | | | | 2 | 5044 | | 1/10/ | 28,2005 |
| 111 | | 30. Name and address of person who | o completed cause of death (Ite | m 23a) (Type, | Print) | | 2 | | |
| NI | | M KEAMAN | o completed cause of death (Ite | unin | not Ten | 7 Rd | BALFI | NO. | 2(22) |
| St | ate | 31. Date filed (Month, Day, Year) | | ature | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 23, 2005 Shortt November 11:28 A Patricia Ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore <u>Gilchrist Center</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Director 54 212-58-4952 July 26, 1951 Maryland Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages I and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or itams 23a or 28a-f show iry or other traumatic event, the Medical Examinar interiments. 1 ☐ Yes 2 No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1616 Alston Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Insurance Producer Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Horace John Kick, Jr. Margaret Louise Dakshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Lewis Shortt, Jr./Husband 1616 Alston Road, Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or odce. 4 □ Donation 5 □ Other (Specify) Pine Grove Cemetery 11/29/05 Parkton, Maryland 21. Shaw For Stryice Loonbeet Bryan W. Clary 22 Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Enter the pisease, or complications that shock, or heal failure. List only one cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause V i al disease or condition resulting in death) Physician Due to (or as a masequence of): cancer YEARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien end s the burial-transit Due to (or as a consequence of). Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide To the Hospital o within 24 hours af To the Funerel Di Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32.

Amoni

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANUES

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32. Registrar's Signature

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N.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38281 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24,2005 Year **Physician** NOV JOHN HARRY SHELLEY 10:10a[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 529 GIFFORD LANE MONKTON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/29/1921 9. Birthplace (State or Foreign Hours 1 XM 2 ☐ F Days 219-16-6090 84 Yrs. MARYLAND Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Directo BALTIMORE MONKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 529 GIFFORD LANE 21111 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 XNo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TRUCK DRIVER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY SHELLEY ELLA SIMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD SHELLEY 2523 COTTER ROAD MILLERS, MD 21102 son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State VALLEY DULANEY 11/28/2005 TIMONIUM, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD 21111 LONACO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 mic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate the control Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 4 1 ☐ Yes 2 ☐ No referred 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🛄 Yes 2 28a. Date of Injury (Month, Day Year) Certification: 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Mural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 18822 11 Mt Carmel Rd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Funeral

Director

or than "natural", or items 23a or 28e-f show the Medical Examiner must be rectilled at

is marked other than

2 should be f and Mental I

of Health item 27

Pages nent of I Department of Importent: if it any injury or o oonce.

Physician

Examiner

use as the burial-transit and

ed by the attending physician detached for use as the burial

ete has been signed page 2 should be det

funeral director,

filled in by the

completely

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s Hospitel or Attending Pl 24 hours after death. • Funeral Director: After ti

To the Hospitel or within 24 hours at To the Funeral D

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certificate be executed

Box 68760.

P.O.

Division of Vital Records,

/Medical

72 hours after

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 2005 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Futurecare Sandtown Winchester Baltimore NA If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 8. Date of Birth (Month, Day Year) Funeral 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) UNKNOWN Months 1□M 20 F Deys Hours 066-34-383 86 Yrs. Director Usuel Residence of Decedent e filed within 72 hours after deeth with the Maryland of Hygiene.

other than "naturel", or flems 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 □ No Director MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1000 N. Gilmor Street 21217 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry unknown 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) INKNOWN 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fii of Health and Mentel H i item 27 is marked oth Be 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Lue Bertha Thomas/ Friend 3405 Bateman Avenue Baltimore, MD 21216 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition permit. Peges 1 Department of He Important: If Iten Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State any injury c 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 11-28-05 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mes Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine ate has been signed by the attending physician end pege 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? this certificate has 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funersi Director: After this certifica filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 Yes 2 No 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 18/01 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1600 W. MOUNTROYN DARSHAN. SALUIA 31. Dete filed (Month, Day, Year) 32 Registrer's Signature State NOV 2 9 2005 Bess. Registrar

DHMH 16 Rev 6/95

| | | | State of Maryland / | | | - | _ | 0000 |
|-------------------|----------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------|------------------------------|----------------------------|------------------------------------------------------|
| | | • | 1 - Stete Registrer | Certificate of L | | , , | 2005 | 38283 |
| | 1.5.1 | | Decedent's Name (First, Middle, Last) | 0 | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | Physicia /Medic | | WANDA SYBO | | | VOVEMBE | n 26 200 | 5 4:30 M |
| • | Examin | er | 4a. Facility Name (If not institution, give street and number) LOD D SAMARITAN HOSPIT | | Location of Death | 0,- | 4c. County of De | |
| | | | GOOD SAMARITAN HOSPITS 5. Social Security Number 6. Sex 7. Age (In yrs. last b | | 71 MOI | 8. Date of Birth | n/a | |
| | Funeral Director | | 213-10-1967 1 M 2 F 91 | Yrs. Months Days | Hours Min. | 8. Date of Birth 9/4/14 | ear) Ma | rthplace (State or Foreign Sountry) ryland |
| | | | Usual Residence of Decedent | | | | | |
| | anylar show | - | , | wn or Location | | | | 10d. Inside City Limits 1 Yes 2 □ No |
| | n the Maryland r 28e-f show | ecto | Md n/a E | Baltimore 10f. Zip Code | | 100 | . Citizen of What C | |
| | death with the Maryland rns 23a or 28e-f show r must be nutified at | Funeral Director | 2108 Boston Street Apt. 401 | 212 | 31 | | USA | |
| | death ms 2 | nera | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hi If Yes, specify Cuba | | cify Yes or No- | 14. Race - Am Black, Wh | |
| õ | or Ite | | 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No | 1 Yes 2 No | Specify: | 110411, 0101) | | |
| 9500-91212 | 72 hours after death with "naturel", or Items 23a or oted Examiner must be | Completed by | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16. | a. Decedent's Usual Occup | ation | 16 | b. Kind of Busines | White |
| <u>က</u> | thin 72 ho e. en "natur Medical | piete | (Specify only highest grade completed) | (Give kind of work done of life. DO NOT use retired | during most of worki d) | ng io | o. King of Dasines | amadany |
| 717 | filed with Hygiene ther the | Com | Elementary/Secondary (0-12) College (1-4or 5+) | Assemb1 | er | W | estern | Electric |
| 2 | 2 should be filed within 72 and Mental Hygiene. Is marked other then "nateumetic event, the Medic | Be (| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name | | | |
| <u>Y</u> | | ပ္ | Francis Nacfalski | | | n Wisni | | 7.041 |
| Maryland | | | | ob. Mailing Address <i>(Street a</i> 1839 Harfor | | | - | |
| _ | s 1 and 3 if Health item 27 other tr | | | of Disposition (Name of ery, crematory or other place | | | c. Location - City of | |
| Ē | nit. Pages artment of l ortent: If it injury or o | | Jab Buriai 2 Ucremation 3 Unemovaritom State | Rosary Cen | i | 0/05 D | undalk. | Md. |
| Baltimore, | parmit. Pages Department of I Importent: If ite any injury or or once. | | 21. Signature of Funeral Servic Doensee | 2K 2 C 2 C 1 C C | ₹ sfktilityFun | eral Ho | me P.A. | 506 |
| m — | g G E E G | | Cuga Cert / | | ndalk Av | | | |
| H | | | 23a. Part1. Enter le disease, I implications that caused the death. Do shock, or hand failure. Little nly one cause on each line. | o not enter the mode of dyin | ig, such as cardiac o | r respiratory arrest | , | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | TORY | FAIL | URE | | |
| 0 | Examiner | | Due to (or as a consequence | e of): | | | | |
| | | Je. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | e of): | | | | |
| | cuted nd ransit | Examiner | that initiated events C. | | | | | |
| 760, | ate be executed hysician and he burial-transit | EX | resulting in death) Last Due to (or as a consequence | e of): | | | | |
| 6876 | physic physic the b | dical | d | | | | | |
| × 6 | eath certifica attending pl | by Physician/Med | IF FEMALE: 23c. If yes, outcome of pregnancy | _ | | | 23d. Date of d | elivery |
| . Box | death e atter | Iciar | in the past 12 months? 4 Pregnant at time of death | th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | · | | Month | Day Year |
| о. О | that the de ed by the a detached f | hys | 9 ☐ Unknown | | | 1 | | |
| | Se US | by f | Part II. Other significant conditions contributing to death but not resulting A T R) A L F L U T 7 E R | in the underlying cause given | en in Part I. | | | to the cause of death? Probably 4 🛣 Unknown |
| 0.0 | w require been si should b | eted | TIMPL I COTTER | | | | | |
| Records, | ne law has b | Completed | | | | 24a. Was an autopsy performe | prior to death? | autopsy findings available completion of cause of |
| æ | | | 25. Was case referred to medical | | 26. Place of Death | | XNo 1 □ Ye | No No |
| \geq | nysicien: The law nis certificate has b i director, page 2 s | o Be | examiner? 1 □ Yes 2 ☑ No Hospital: ☑ Inpatient 2 □ ER/C | Outpatient 3 DOA | er: 4 🗆 Nursing Hor | | ce 6 Other (Sp | ecify) |
| Division of Vital | Attending Physicien: r death. ector: After this certificator, the funeral director, by the funeral director, i | on: T | 27. Manner of Death 28a. ate of Injury 28b 1 Natural 5 □ Pending (Month, Day Year) | . Time of 28c. Injury Wor | y at k? | 28d. Describe how | | |
| S | tendii leath. tor: A the fu | cati | 2 Accident investigation | | Yes 2 □ No | 296 Lagatina (Ctra | at and Number or | Burni Bauta Number |
| \leq | l or Attending I after death. Director: After I in by the funer | Certification; | 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide | rarm, street, factory, office | | City or Town, | | Rural Route Number, |
| | Hospitel 14 hours 15 Funeral 16 tely filled | | 29a. Certifier 1 Certifying Physicien: To the best of my knowled | ge, death occurred at the tir | ne, date and place, | and due to the cau | se(s) and manner | as stated. |
| | | edical | (Check only one) 2 Medicel Exeminer: On the basis of examination a and manner stated. | | | | | |
| | To the within 2 To the complet | Σ | 29b. Signature and title of certifier | 29c. Licens | | | I. Date signed (Mo | |
| , | d | | Monisha Bahl, M. | | 07871 | SIN | DVEMBL | n 26 2005 |
| 15 | • | | 30. Name and address of person who completed cause of death (Item 23a | (Type, Print) GOOJ | DSAM | ARITAN | POSI | TAL |
| | Sta | ite | 30. Name and address of person who completed cause of death (Item 23a MANISHA BAHL 560 LC 31. Date filed (Month, Day, Year) 32. Agistrar's Signature | AMVEN | OUVLEV | MARYI | LAND | 21239 |
| E | Regist | | 31. Date filed (Month, Day, Year) NOV 2 9 2005 32. Sigistrar's Signature | Specter | | | | |

| | | | ricase | Ctoto of Man | | | | • | - | |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------|-----------------------------------------|--------------------------------------------------|------------------------------|--------------------------|--------------------------------------------------|
| | | | For State Registrar | State of Man | yland / i | Department of | | nentai Hygi | ^{en2} 005 | 38284 |
| | | 27 | | | | Certificate o | t Death | | g. No. | |
| | Physicia | an | Decedent's Name (First, Middle, La | st) | | | | 2. Date of Death | Day Year | 3. Time of Death |
| | /Medic | | JOHN | | | SPIRT | | November | 18 200 | 55.28 PM |
| | Examin | er | 4a. Facility Name (If not institution, giv | re street and number) | 1 | 4b. City, Town | n, or Location of Death | 01 | 4c. County of Dea | ith |
| | de f | | sinai Hospite | e of ball | imore | Bal | limore (| ity | | N/A |
| | Funeral | | 5. Social Security Number 6. S | | n yrs. last bii 1 | rthday) If Under 1 Ye. Yrs. Months Day | | 8. Sate of Birth 12/17/19 | 9. Bii | thplace (State or Foreign ountry) |
| 7 | Director | | 182-18-3610 Usual Residence of Decedent | X M 2 □ F 8 | 1 | 115. | | 12/1//1 | 123 | VA |
| Z. | and w | | 10a. State 10b. County | 10 | 0c. City, Tow | n or Location | | | | 10d. Inside City Limits |
| æ | danyi f sho | ō | MD BALTIMO | RF | TOWS | ON | | | | 1 ☐ Yes 2 No |
| 3 | 28a- | Director | 10e. Street and Number | | 10110 | 10f. Zip Code | <u> </u> | 10 | g. Citizen of What C | |
| ran Bir | death with the Maryland ms 23a or 28a-f show r must be notified at | | 204 EAST JOPPA | DOAD ADT #6 | 507 | 21286 | | | U.S.A | |
| 3 | leath | Funerai | 11. Marital Status | 12. Was Decedent Eve | | | | ecity Yes or No- | 14. Race - Am | |
| | fler | Fu | 1 ☐ Never Married 2 ☐ Married | Armed Forces? | | | of Hispanic Origin? (Sp uban, Mexican, Puerto | Rican, etc.) | Black, Whi | te, etc. |
| (1) | hours after tural', or ite | by | 3 ☐ Widowed 4 X Divorced | If Yes , Give Year or Dates: | | 1 ☐ Yes 2 💢 N | No Specify: | | Specify: | WHITE |
| 5-003 | 72 hours after death with the Marylan "natural", or items 23a or 28a-1 show cited Examiner must be notified at | ted | 15. Decedent's E | ducation | 16a | . Decedent's Usual Occ | cupation | 1 | 6b. Kind of Business | Industry |
| _ | | pie | (Specify only highest gr. | College (1-4or 5+) | | | ne during most of work ired) | | | |
| νυθειέπ land 2121 | be filed within 72 ho ital Hygiene. Ind other then "natur event, Ita Medical | Completed | Elementary/Secondary (0-12) | | S. | ALESMAN | | H | OME IMPRO | VEMENT |
| ₹ E | be filed tal Hygie d other event, III | Be (| 17. Father's Name (First, Middle, Last |) | | | 18. Mother's Nam | e (First, Middle, M | aiden Sumame) | |
| <u>a</u> | should bind Menti | 70 [| MORRIS | | | SPIRT | FANNIE | | SCHA | FRITZ |
| Amer Maryland | permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other traumatic event, Ite M. 901ce. | | 19a. Informant's Name/Relationship (| Type, Print) | 198 | o. Mailing Address (Stre | eet and Number or Rur | al Route Number, | City or Town, State, | Zip Code) |
| 4 | and and n 27 | | BRIAN SPIRT / NEI | | - I | 5 VALLEYST | | EVERNA PA | ARK, MD 21 | .146 |
| 1 2 o | of Her | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | | 20b. Place o 1ARYLA | of Disposition (Name of | dace) | Date 2 | Dc. Location - City or | Town, State |
| Patien Baltimore, | Pag ment ant: I ury o | | 4 Donation 5 Other (Special | (y) | MAKYLA | ND THE TERMS | 11/28 | 3/2005 0 | WINGS MIL | LS, MD |
| Co # | permit. Departr Imports eny inj | | 21. Signature of Funeral Service Lice | nsve | | 22. Name and Add | dress of Facility SOL | LEVINSO | N & BROS. | , INC. |
| | Dep Imp | | pay/ lay | <u></u> | | 8900 REIS | STERSTOWN F | ROAD - PI | KESVILLE, | MD 21208 |
| | | | 23a. Party. Enter the disease, or comshock, or heart failure. List only | plications that caused the | e death. Do | not enter the mode of o | tying, such as cardiac | or respiratory arres | st, | Approximate Interval Between |
| de | Physician | | Immediate Cause (Final disease or condition | ROLD | noto | Du fail | 1150 | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a c | onsequence | of); | <i>w.c.</i> | | | Tuesday. |
| | Examiner | | Sequentially list conditions | Renal | Fo | Slure | | | | 7 days. |
| / | D = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a c | onsequ nce | o): | | | | 0 |
| ٧ | and -transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | |
| 60, | | | resolding in deathy cast | Due to (or as a c | onsequence | of): | | | | |
| | w = 0 | dicai | | _ d | | | | | | |
| 89 x | ling p | Physician/Medi | IF FEMALE: | 20- 11 | | | | | | **** |
| Вох | ath c | lan/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of p | Fetal death | | | | 23d. Date of de Month | livery Day Year |
| o. | the a | sic | 1 □ Yes 2 □ No 9 □ Unknown | 4□Pregnant at tim 9□ Unknown | e of death | 5 Other (specify) | | | | , |
| P.O. | that the de ad by the detached | | Part II. Other significant conditions | contributing to death but n | not resulting i | n the underlying cause | awan in Part I | 23e Did toba | cco use contribute t | o the cause of death? |
| Ś | es be po | by | /> L | east Fa | · Our | ir the disconying educe | givoir ii i ait i. | 1 ☐ Yes | | robably 4 Unknown |
| 0.0 | w requir been si should | etec | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | www.ju | ume | | | | | |
| ec | e law has l | Completed | | | | | | 24a. Was an autopsy perform | prior to | utopsy findings available completion of cause of |
| = | cate | | | | | | | | | 2 DM6 |
| <u> </u> | ician certif ector | Be | 25. Was case referred to medical examiner? | Hospital: | | | 7.th | h (Check only one, | | |
| of | ding Phyaician: The I h. After this certificate ha funeral director, page | - To | 1 Yes 2 No 27. Manner of Death | 1 Linnpatient | 2 ER/O | arpationt 3 DOA | | | ce 6 □Other (Spe | ocify) |
| - L | Jing After funer | ion | 1 Matural 5 ☐ Pending | 28a. Date of Injury (Month, Day Y | ear) | Injury V | Vork? | 28d. Describe how | injury occurred | |
| <u>:S</u> | deatl deatl stor: r the | ca | 3 ☐ Suicide 6 ☐ Could not b | OB Place of Jaius | - At home fo | arm, street, factory, office | | 29f Logation /Stre | et and Number or R | ural Paula Alumbas |
| Division of Vital Records, | To the Hospital or Attending Physician: which 24 hours after death at the function of the Funeral Director. After this certifica completely filled in by the funeral director, | Certification: | 4 Homicide determined | building, etc. (| Specify) | , street, ractory, offic | ~ | City or Town, | | orar noble ivalibel, |
| | spita ours neral filled | | 29a. Certifier 1 Certifying Pl | nysicien: To the best of n | ny knowledo | e, death occurred at the | time, date and place | and due to the car | sa(s) and manner a | s stated |
| | • Ho. 24 h • Fur | edical | (Check only 2 Medical Exer | miner: On the basis of ex | amination ar | nd/or investigation, in m | y opinion, death occur | red at the time, dat | e and place, and du | e to the cause(s) |
| | fo th within fo th | Me | 29b. Signature and title of certifier | | | 29c. Lice | ense number | 290 | d. Date signed (Mon | |
| | . > = 0 | | > Hongh | -MD | | Do | 306332 | ,2 No | vember 18 | 12005 |
| | . 1 | | 30. Name and address of person who | completed cause of deat | h (Item 23a) | (Type, Print) | | | | * |
| | 4 | | Anagradas a le | nah. MD | Sina | i Hocostel | of Baltina | PIL V. | | |
| 1 | Sta | te | 31. Date filed (Month, Day) Year) | 32. Redistrar's | Signature | had! | 7 | 9.00 | | |
| | Registr | ar | NOV 2 9 | 2005 | es St. | 29c. Lice D((Type, Print)) MCCPITAL | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| | 1 - State Unpend Item 2 Registrar 1. Decedent's Name (First, Middle, Last | | | | | | | 2. Date of D | | | 3. Time of De | |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------|----------------------------------------------|------------------------------|----------------------|-------------------------|-------------------------------|-------------------------------------------|-----------------------------------------------|-----------------------------------------|--|
| ian | Albert John Smi | | | | | | | Month | Day | | | |
| cal | 4a. Facility Name (If not institution, give | street and number) | | 4h City | Town, or Lo | cation o | f Death | Novem | | 3, 200! County of Dea | | |
| ner | | | | | | oution o | Journ | | | | | |
| | 5. Social Security Number 6. Se | Apt. D x 7. Age (In y | rs. last birthe | | 1 Year If | Under 2 | | 8. Date of Bi | rth | | re County thplace (State or Fountry) | |
| | 015 70 0500 |]xm 2□F 4 | +9 Yr | s. Months | Days H | Hours | Min. | (Month, D | ay, Year) } . 19' | | ryland | |
| | Usual Residence of Decedent | | | | | | · · | UCL | , 17- | 70 I Ma | ry ranu | |
| | 10a. State 10b. County | | City, Town | | | | | | | | 10d. Inside City I | |
| cto | MD Baltimo | re Co. Du | ındall | k | | | | | | | 1 ☐ Yes 2 | |
| Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 Dunran Road Apt. D 21222 USA | | | | | | | | ountry? | | | |
| ra | 2907 Duillan Koa | | 21222 | | | | | | | | | |
| Funeral | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | n U.S. | Was Deced If Yes, spec | ent of Hispa ify Cuban, N | anic Orig Mexican | gin? (Spe , Puerto l | cify Yes or N Rican, etc.) | | Race - Ame Black, Whi | te, etc. | |
| by Fi | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☐ No Specify: | | | | | Specify: White | | | |
| D D | 15. Decedent's Edu | | 16a D | ecedent's Usua | Occupation | | | | 16h Ki | nd of Business | /ladusta/ | |
| Set | (Specify only highest grad | le completed) | (0 | Give kind of wor | k done durir | ng most | of working | ng | 100.10 | 10 01 003111033 | viridustry | |
| Completed | Elementary/Secondary (0-12) | College (1-4or 5+) N / A | Pai | inter | | | | | S _O 1 | elf-Employed | | |
| To Be Completed by Funeral Director | 17. Father's Name (First, Middle, Last) | | | L.1.1. C. S., . L. | 18 | . Mothe | r's Name | (First, Middle | , Maiden | Sumame) | TOYEU | |
| To B | Albert Jenkins | Smith | | | | Dor | cis | Bowma | n | | | |
| - | 19a. Informant's Name/Relationship (7) | /pe, Print) | 19b. N | Mailing Address | (Street and | | | | | Town, State, | Zip Code) | |
| | Leona Nicolaidi | s-Sister | 346 | 5 S. L | ehigh | n St | tree | t Bal | t. M | ID 212 | 24 | |
| | 20a. Method of Disposition | 1 | b. Place of D | isposition (Nam crematory or or | e of her place) | | D | ate | 20c. Lo | cation - City or | Town, State | |
| | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 11-26-05 Baltimore MD | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee MO 1259 22. Name and Address of Facility Kaczorowski Funeral Home | | | | | | | | | | | |
| | MULL | - | | 1201 1 | Dunda | 1 lk | Ave | nue B | alt. | MD 2 | 1222 | |
| | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | lications that caused the d | leath. Do no | t enter the mod | of dying, s | such as | cardiac o | r respiratory | arrest, | | Approximate Interval Between | |
| | Immediate Cause (Final disease or condition a Cirrhosis of the Liver | | | | | | | | | | Onset and De | |
| | resulting in death) a. Ultimosis of the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the l | | | | | | | | | | | |
| | Sequentially list conditions | Alcohol Abu | ıse | | | | | | | | | |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | | | |
| am | that initiated events C. | | | | | | | | | | | |
| E | 1650king in Ceality Last | Due to (or as a consequence of): | | | | | | | | | | |
| dica | | d | | | | | | | | | | |
| Physician/Medic | IF FEMALE: 230 If was outcome of pregnancy | | | | | | | | | | | |
| ian | 23b. Was decedent pregnant in the past 12 months? | | | | | | | 2 | 23d. Date of delivery Month Day Yea | | | |
| ysic | 1 Yes 2 No 9 Unknown 9 Unknown | | | | | | | | | | | |
| H _H | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba | | | | | | | tobacco u | acco use contribute to the cause of death | | | |
| d by | 1 ☐ Yes | | | | | | | Yes 2 | | | | |
| Completed | | | | | | | | 24a. Wa | | | | |
| m d | | | | | | | | auto | | prior to death? | utopsy findings av completion of cau | |
| ပိ | or W. | | | | | | | 1 Nes | 2 No | y Yes | 2 □ No | |
| Be | 25. Was case referred to medical examiner? | Hospital: | 2 C C C C | | Other | | | (Check only | | www. | st co | |
| Certification: To Be Comp | 1 ∑Yes 2 No 27. Nanner of Death | 1 inpatient | 4 Aurising Home 5 Hesidence (Specify) | | | | | ecify) at sc | | | | |
| Certification | 14 Natural 5 ☐ Pending | (Month, Ďaý Year) Injury Work?" n M 1 □ Yes 2 □ No | | | | | | | | | | |
| fica | 3 Suicide 6 Could not be | | | | | | ural Route Numbe | | | | | |
| erti | 4 Homicide determined | building, etc. (Sp. | ecify) | 2., | | | | City or To | wn, State, | | | |
| | 29a. Certifier 1 ☐ Certifying Phy | sician: To the best of my | knowledge | death occurred | at the time | date and | d place. a | and due to the | cause(s) | and manner a | s stated. | |
| Medical | | iner: On the basis of exame and manner stated. | nination and/ | or investigation, | in my opinio | on, deat | th occurre | ed at the time | , date and | place, and du | e to the cause(s) | |
| 0 | 29b. Signature and title of certifier | Ma | | 290 | License nu | umber | | | 29d. Dat | e signed (Mon | th Day Year) | |
| ≥ | 230. Signature and titiget columning | | | | | | | | | | in, Day, roar, | |

State Registrar

31. Date filed (Month, Day, Year)
NOV 2 9 2005

use of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

| | | | For State Registrar | State of Marylar | | artment of Health tificate of Deat | | ital Hygie | | 38286 | | |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------|--|--|
| | | | Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year 3. Time of Death | | | | | | | |
| | Physicia /Medic | | ANNA | /ANT | ARO | S | | OVEMBOR | | 50815AM | | |
| | Examin | er | 4a. Facility Name (If not institution, give s | | | 4b. City, Town, or Location | | 4c. County of Dea | ARUNDEL | | | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs | 47 | If Under 1 Year If Und | ler 24 Hrs. 8. [| Date of Birth | | thplace (State or Foreign | | |
| | Funeral Director | | | M 2X)F | 87 Yrs. | Months Days Hours | s Min. Ma | Month, Day, Yea 1y 03 1 | 918 | Greece | | |
| (| and * | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | | | | 10d, Inside City Limits | | |
| | Maryli f sho | tor | Maryland Anne Ar | undel | | Pasa | dena | | | 1 ☐ Yes 2 🔀 No | | |
| | h the | Director | 10e. Street and Number | didei | | 10f. Zip Code | dend | 10g. (| Citizen of What C | ountry? | | |
| | 72 hours after death with the Maryland natural; or Items 23s or 28e-f show Jical Executar must be notified at | ralD | 17 Sloan Lane | | | 1 | 122 | | USA | | | |
| 21215-0036 | | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | Was Decedent of Hispanic (f Yes, specify Cuban, Mexic 1 □ Yes 2☑ No Speci | can, Puerto Rica | Yes or No- in, etc.) | 14. Race - Ame Black, Whi | | | |
| 2-0 | 72 ho natur | eted | 15. Decedent's Edu | | mpleted) (Give | | edent's Usual Occupation a kind of work done during most of working | | | 16b. Kind of Business/Industry | | |
| 121 | filed within Hygiene. Ither than " | Completed | Elementary/Secondary (0-12) College (1-4or 5+) 12 Dressmaker | | | | | Clothing | | | | |
| | filed with Hygiene. other thar ent, U.e.N | To Be Co | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, M | | | | | rst, Middle, Maid | | | | |
| ılan | 2 should be filed within and Mental Hygiene. Is marked other than eumatic event, If a M. | | John | Metrol | costa | Ky | riaki | \Box |)iamono | dopoulo | | |
| Maryland | 2 sho and h ls ma | | 19a. Informant's Name/Relationship (Ty) Constance Cotter | | | ng Address (Street and Num | | | | Zip Code) | | |
| | ges 1 and 2 should be filed within 72 hr t of Health and Mental Hygiene. If item 27 is marked other than "natur or other treumatic event, it a Musical | 68 | 20a, Method of Disposition | (daughter) | | Sloan Lane, sition (Name of natory or other place) | | | Location - City or | Town, State | | |
| TOL | Pages nent of I nnt: If its iry or o | | 1 XBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) | emoval from State | | | Nov. Date 2005 | | otch Plai | | | |
| Baltimore, | permit. Pag Department Importent: I any injury o | '4 Donation 5 Other (Specify) Hillside Cemetery 2005 Scotch 21. Sign turn of Funeral Service 22. Name and Address of Facility Stallings Funer 3111 Mountain Road, Pasadena, | | | | | | | | Home, P.A. | | |
| | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset | | | | | | | | | |
| | Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a conse | T/C Sequence of): | QUAMOUS | | | CER | Onset and Death 2 year PS | | |
| | 9d sit | iner | if any, leading to immediate | | | | | | | | | |
| · | cate be executed physician and the burial-transit | Examin | | | | | | | | | | |
| 8760, | ysicial ysicial | dicall | d | | | | | | | | | |
| 9 | artifica ing ph e as th | | IF FEMALE: | | | | | | | | | |
| .O. Box | The law requires that the death certifics ate has been signed by the attending phoage 2 should be detached for use as I | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown | tal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of de Month | livery Day Year | | |
| s, P | es that igned b | by P | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? | | | |
| ord | w require been si | | | | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknov | | | | | | | |
| al Records, | | Completed | | | | | | 24a. Was an autopsy performed' 1 Yes 2 | death? | utopsy findings available completion of cause of | | |
| Vital | Physician: The this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? | lospital: 1 ☐ Inpatient 2[| ☐ ER/Outpatier | Other | ace of Death (Cl | | 6 □Other (Spe | ogifu) | | |
| of | | | 27. Manny of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time o | | | Describe how in | | ecity) | | |
| Division | Atten r deat ector: by the | atio | 1 Accident 5 Pending investigate | M 1 Yes 2 No | | | □No | | | | | |
| | | Medical Certification: | 3 Suicide 6 Could not be determined | | | | 28f. | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | To the Hospitel or within 24 hours after To the Funerel Dir completely filled in | | 29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami | sician: To the best of my kr ner: On the basis of examir and manner stated. | nowledge, deat nation and/or in | h occurred at the time, date vestigation, in my opinion, o | and place, and death occurred a | due to the cause It the time, date a | e(s) and manner a and place, and du | s stated. e to the cause(s) | | |
| | To t To t | 2 | 29b. Signature and title of certifier | MA | Mr 1 | 29c, License number 10 10 10 10 10 10 10 10 10 10 10 10 10 | / | | Date signed (Mon | / | | |
| | 3 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL AJNKROM 8601 VOTERANS HIGHWAY MILLERSVILLE MD | | | | | | | | | |
| | Sta Regist | | 31. Date filed (Month, Day, Year) NOV 2 9 2 | 32. Registrar's Sign | M. A | boots | | | | | | |

State of Maryland / Department of Health and Mental Hygiepen 05 38287 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22, 2005 John P. Thomas November 4:56 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 683 Shore Road Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 25, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 (XM 2 □ E 1922 Pennsylvania 165-12-1547 82 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examinar manner. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 683 Shore Road 21146 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 12 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Fighter Pilot Marine Corps 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton Addison Thomas Kathryn Glynn ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Huestis, Daughter 683 Shore Rd., Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation _5 ☐ Other (Specify) National Crematory 11-25-2005 Falls Church, Virginia 21. Signature Fineral 22 Name and Address of Facility
Witzke Funeral Home of Catonsville, 1630 Edmondson Ave. Catonsville, MD 21228 M01290 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or height failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in interdiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence attending physician and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No P 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural death. 1 Yes 2 No 2 Accident hours after deat uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and (itle of dentifier 29d. Date signed (Month, Day, Year) 0051297 se of death (Item 23a) (Type, Print)

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LOC 30. Name and address of person who completed UDO CITI MY arender D 4055 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

| State of Maryland / Department of Health and Mental Hygiene 15 38288 | | | | | | | | | | | |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------|---------------------------|---------------------------------|-----------------------------------------------------|--|--|
| | 1 = State Registrar Amend Item #20b Per FH G850 Certificate of Heath Reg. No. | | | | | | | | | | |
| 12 | Physici | .∗ an | 1. Decedent's Name (First, Middle, La | st) | - | Trust | 2. Date of Death Month | Day 77 Year | 3. Time of Death | | |
| | /Medic Examin | al | 4a. Facility Name (If not institution, giv | ş street and number) | 4b. Cit | y, Town, or Location of Dea | th | 4c. County of Dealt | | | |
| 2 | Examili | ici - | Johns HOOK | ins Hosp | ital 7 | 3altimo | re | NI | 4 | | |
| | Funeral | 7= | 5. Social Security Number 6. S | ex 7. Age (In vrs. | /ast birthday) If Und Month | ler 1 Year If Under 24 Hr s Days Hours Mir | | earlog Ago | oplace (State or Foreign untry) | | |
| 1.00 | Director | | Usual Residence of Decedent | 77 | 115. | | Aug.10 | 17711110 | ar grana | | |
| | death with the Maryland rms 23a or 28a-f ehow | _ | 10a. State 10b. County | 10c. Cit | ty, Town or Location | | | | 10d. Inside City Limits | | |
| | | ecto | Maryland N/ | A E | | ore | 10 | 677 | 1 XYes 2 No | | |
| | with t | Funeral Director | 10e. Street and Number | ara Aug | 101, 4 | 2120/a | Tog. | . Citizen of What Co | A | | |
| | ours after al', or Ite | nera | 11. Marital Status | 12. Was Decedent Ever in U | .S. 13. Was Dec | cedent of Hispanic Origin? (becify Cuban, Mexican, Pue | Specify Yes or No- | 14. Race - Amer Black, White | | | |
| 36 | | by Fu | 1 Never Married 2 Married | 1 ☐ Yes 2 17 No If Yes, Give | | 2 No Specify: | no mean, etc., | Specify: | 1 = = V | | |
| Ö | | | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E | Year or Dates: | 16a. Decedent's Us | sual Occupation | 161 | b. Kind of Business/I | ndustry | | |
| 215 | C = | Completed | (Specify only highest gra Elementary/Secondary (0-12) | de completed) College (1-4or 5+) | (Give kind of v | work done during most of w | orking | 0 / / . | 011 | | |
| 2 | be filed within tal Hygiene. In other than event, the Mercent | Соп | | | Stu | ident | | ublic | School | | |
| Maryland 21215-0036 | y a b | Be c | 17. Father's Name (First, Middle, Last | Blackwall | Tr | 18. Mother's Na | ame (First, Middle, Mai | T () (H | | | |
| ary. | ifficate be executed by Adams and 2 shall and 2 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall and 3 shall | 은 | 19a. Informant's Name/Relationship (| Type, Print) (mother | 19b. Mailing Addre | ess (Street and Number or F | Rural Route Number, C | ity or Town, State, Z | lip Code) | | |
| | | | Ms Cherlis | e A. Truitt | 5211 | Barbara | Ave. B | alto. Mo | 1,21206 | | |
| altimore, | | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ | F3.51 / | Place of Disposition (A cemetery, crematory o | r other place) | 1 3 | c. Location - City or 1 | Fown, State | | |
| Ē | | | 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service/Dce | | Mt.Carnel | and Address of Facility | /05/05 | Balto. | Ma. | | |
| Ba | | | Jana no | X Bu | 11 3955 | 1 1 12 | Fuzeral | Home P.1 | 9. | | |
| - 38 | | | 23a. Parti. Enter the dispase, or comshock or heart failure. List only | plications that caused the deal | th. Do not enter the m | ode of dying, such as cardi | ac or respiratory arrest | MAIG | Approximate Interval Between | | |
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| | | | resulting in death) | Due to (or as a consec | | 9 | | | laures and | | |
| | | er | Sequentially list conditions, if any, leading to immediate | Due to (or as a criseo | year- | | | | | | |
| | | Examin | cause. Enter Underlying Cause (Disease or injury that initiated events | . chemoth | lyear | | | | | | |
| 60, | | | resulting in death) Last | Due to (or as a consect | I near | | | | | | |
| 68760 | | edical | | d. Offerall | CD1144C | | | | 1 0/2001 | | |
| Вох | | M/u | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregnantial Live birth 2 Feta | | 0.0000000000000000000000000000000000000 | | 23d. Date of deli | very | | |
| | ne deat the attr | Physician/Me | in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown | 4☐Pregnant at time of o | | | | Month | Day Year | | |
| P.0 | that the do ad by the detached | | Part II, Other significant conditions | contributing to death but not res | sulting in the underlying | cause given in Part I. | 23e. Did tobac | co use contribute to | the cause of death? | | |
| rds, | quires than signed | Completed by | thrombocyto | penia | | | 1 🗆 Yes | 2No 3□Pro | obably 4 □Unknown | | |
| SO | aw requise been 2 shouk | plete | | J | | | 24a. Was an autopsy | 24b. Were aut | topsy findings available omit letion of cause of | | |
| E E | The lav | Com | | | | | performed 1 Yes 2 | d? death? No 1 ☐ Yes | 2 No | | |
| Vita | To the Hospital or Attending Physician: The Is within 24 hours effer deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page 2 | Be | 25. Was case referred to medical examiner? | Haspital | | | | | | | |
| of | | T | 1 Yes 2 No | 28a. Date of Injury (Month, Day Year) | ER/Outpatient 3□ 28b. Time of | 28c. Injury at Work? | Home 5 ☐ Residenc | | ufy) | | |
| ion | | Certification; | 1 Vatural 5 Pending 2 Accident investigation | | . , | | | | | | |
| Division of Vital Records, | | | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | be de 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Numbuilding, etc. (Specify) | | | | | ral Route Number, | | |
| | pital o | Cel | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| | e Hos | Medical | | miner: On the basis of examina and manner stated. | ation and/or investigati | on, in my opinion, death occ | curred at the time, date | and place, and due | to the cause(s) | | |
| | To th To th Comp | Me | 29b. Signature and the of certifier | ? | | 29c. License number | | Date signed (Month | • | | |
| | | | / An// | M | D | Res-00 | 0 /4 | ovember. | 23,2005 | | |
| D. | T | | 30. Name and addless of person who | (| m 23a) (Type, Print) | Res-00 eStreet | 2 | ine Mi | 2124.7 | | |
| | | ate | 31. Date filed (Month, Day, Year) | . Registrar's Sign | ature de la la la la la la la la la la la la la | - Alleel | intill | COTE , STORY | - 01004 | | |
| | Regist | | NOV 2 9 200 | 15 Allegar De | Con the second | | | | | | |

| | | • | For State Registrar | State of Ma | | epartment of H Certificate of I | | | jiene2 (| 05 | 38289 |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------|---------------------------------------------|----------------------------------|-------------------------------|----------------------------|----------------------------------------------------|
| | Dhuaisia | | 1. Decedent's Name (First, Middle, La | ist) | | | | Date of Dea Month | ith Day | Year | 3. Time of Death |
| | Physicia /Medic | | HARVEY E. VAUGE | IN | | | | 11.84. | 2005 | | 4:35 AM |
| | Examin | | 4a. Fecility Name (If not institution, git MARYLAND GENER | | | BALTIMOR | Location of Death | | 4c. Coun | ty of Death | |
| | Funeral | | Social Security Number 6. | Sex 7. Age | (In yrs. last birth | | If Under 24 Hrs. Hours Min. | 8. Date of Birth | n /. Year) | 9. Birth | place (State or Foreign |
| | Director | | 21.(-40-2281 | 1 ⊠ M 2□F | 67 Y | rs. Months Days | TIOUTS INIT. | (Month, Day | 1938 | | place (State or Foreign ntry) MD |
| | pu * | } | Usual Residence of Decedent 10a, State 10b, County | | 10c. City, Town | or Location | | | | | 10d. Inside City Limits |
| | Aaryla f •ho | ٥ | MD NA | | BALTIMO | | | | | | 1 KEYes 2 □ No |
| | with the Maryland a or 28a-f ehow | rect | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | f What Cou | ntry? |
| | h with | | 1432 Mccuuch | STREET | | 21217 | | | U | ISA | |
| ~) | eme 23 | Funeral Director | 11. Marital Status | 12. Was Decedent E Armed Forces? | ver in U.S. | 13. Was Decedent of H If Yes, specify Cuba | ispanic Origin? (Spann, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Ra Bi | ace - Ameri ack, White, | |
| 3,8 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural; or items 23a or 28a-f show appriant: if item 27 is marked other than "netural; or items 23a or 28a-f show appriant or other traumatic event, the Medical Examinating Items (1945) at appres. | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced | 1 ☐ Yes 2 🐼 No If Yes, Give Year or Dates: | 0 | 1 ☐ Yes 2 🗷 No | Specify: | | Spec | ify: BLA | ער |
| LUE 215-003 | tural | ed b | 15. Decedent's E | ducation | 16a. | Decedent's Usual Occup | ation | MNK | 16b. Kind of | | Idustry LUK |
| 3,5 | nin 72 in ne | Completed | (Specify only highest gi | rade completed) College (1-4or 5- | +) | Decedent's Usual Occup (Give kind of work done life. DO NOT use retired | during most of worki 1) | ing | | | |
| 712 | d with | Com | 12 TH GRADE | NA | | | | | | | |
| 丰富 | be file tal Hy d oth | Be | 17. Father's Name (First, Middle, Las | t) | | | 18. Mother's Name | | Maiden Suma | ame) | |
| √ | Men Marke Marke | 은 | WILLIE ERVIN 19a, Informant's Name/Relationship | (Torre Crist) | 10h | Mailing Address (Street | MARIE B | | r City or Tow | n State 7i | n Cada) |
| Z S S S S S S S S S S S S S S S S S S S | d 2 st th and 17 ie n traun | l ii | VERONICA THOMPS | | 1 | 3 N. CAREY | - | TIMORE | | 2121 | |
| - J | Heal Heal tem 2 other | | 20a. Method of Disposition | 5 010 | 20b. Place of | Disposition (Name of v, crematory or other place | , , | Date | 20c. Location | | |
| 70 | Pages ent of nt: if i | g. | 1 ☐ Burial 2 🗗 Cremation 3 decision 4 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control | | GREEN | | Ĩ lu·30 · | 05 | BALTIMO | DRE N | nD . |
| Baltin | permit. I Departm Importar eny inju | | 21. Signature of Funeral Service Lice | • . | CANEDIO | 22. Name and Addre | | | | 107 | |
| — ä | Dermi Depa Impo eny ir | | John With | | | 551 BAL10, N | ATT PIKE | BALTO. N | 10 2122 | 9 | |
| | | Г | 23a. Parth. Enter the disease, or co- shock, or heart failure. List ont | mplications that caused y one cause onyeach lin | the death. Do n e. | ot enter the mode of dyir | ng, such as cardiac | or respiratory ar | rest, | | Approximate Interval Between Onset and Death |
| 3 | Physician | | Immediate Cause (Final disease or condition | a Du | Unger | af Can | eer | | | | 1/03 |
| | /Medical Examiner | | resulting in death) | Due to (or as | a consequence o | of): | | | | | 1446 |
| | | er | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a | a consequence of | of): | | | | | |
| V | uted d | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | |
| 6 | cate be executed physician and the burial-transit | Exa | resulting in death) Last | Due to (or as a | a consequence o | of): | | | | | |
| 8760, | cate be physici the bu | dlcal | • | d | | | | | | - | |
| 9 | | | IF FEMALE: | 23c. If yes, outcome | of pregnancy | | | | 224 [| Date of deliv | 1001 |
| Вох | Attending Physician: The law requires that the death certific death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 1□Live birth 4□Pregnant at | 2 Fetal death | 3 ☐Ectopic pregnance 5 ☐ Other (specify) _ | / | | | Month | Day Year |
| o. | it the di by the tached | ysk | 1 Yes 2 No 9 Unknown | 9☐ Unknown | | | | | | | |
| Division of Vital Records, P.O. | s that med b e deta | by Pi | Part If. Other significant conditions | contributing to death bu | ut not resulting in | the underlying cause given | ren in Part f. | | | | the cause of death? |
| ğ | w requires been sign should be | edit | 171Cohel | 1 wise | | | | 101 | res 2⊡No | 3 ☐ F ro | bably 4 Unknown |
| သ | e law re has be | Completed | Seizur | De Sorte | | | | 24a. Was autop | SV | prior to co | opsy findings available ompletion of cause of |
| <u>~</u> | The I | Con | | | | | | 1 ☐ Yes | rmed? 2⊡No | death? | 2 No |
| Vita | sician: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | _ Ott | 26. Place of Deat | | | | |
| to | Phys r this ral dir | 2 | 1 Yes 2 No | 28a. Date of Injur | ry 28b. T | tpatient 3 DOA | 4 Nursing Ho | ome 5 ☐ Resid 28d. Describe I | | | ify) |
| o | ding Ph th. : After thi funeral | ton | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat | (Month, Day | y Year) li | njury ₩o | rk? Yes 2 □ No | | | | |
| /isi | Attendir death | ifica | 3 Suicide 6 Could not | be 28e. Place of Inju- | ury - At home, fa | rm, street, factory, office | | 28f. Location (S | | mber or Rui | ral Route Number, |
| á | s afte | Certification: | 4 Horricide | building, etc | c. (Specify) | | | 0.ly 0. 1 0. | , 0.0.0) | | |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo | Medical | 29a. Certifier 1 Certifying (Check only one) | Physician: To the best of aminer: On the basis of and manner sta | examination an |), death occurred at the ti d/or investigation, in my | me, date and place, opinion, death occur | and due to the red at the time, | cause(s) and date and plac | manner as e, and due | stated. to the cause(s) |
| | thin 2 thin 2 omple | Mec | 29b. Signature and title of certifier | and manner sta | ateu. | 29c. Licen | se number | - | 29d. Date sign | ned (Month | , Day, Year) |
| | ⊬ ≯ ⊢ ŏ | | >/ Glun | -luk | | 1 | 45470 | | 11/ | 28/05 | · |
| | 7 | | 30. Name and dress of person with | completed cause of d | leath (Item 23a) | (Type, Print) | nlet | BNIT | - | | |
| | Q | ate | 31. Date filed (Month, Day, Year) | | ar's Signature | 11111111 | V) (/ | -11/ | -(1) | 1-1: | |
| | Regist | | NOV 2 9 | | we It | Species . | | | | | |

| | | 1 | For State Registrar | State of Maryland | | artment of H | | | ene 0 0 5 | 38290 |
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| | Physici /Medic | an | 1. Decedent's Name (First, Middle, Last | | + 5+ | one | | 2. Date of Death Month | | 3. Time of Death |
| | Examin | er | 4a. Facility Name (If not institution, give Anne Arundel Medic | | | Annapoli | | | 4c. County of Dea | |
| | Funeral Director | | 5. Social Security Number 6. Se 164-07-5349 | 7. Age (In yrs. la | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, July 14 | , 1915 9. Bi | rthplace (State or Foreign ountry) PA |
| | Maryland -f ehow | | 10a. State 10b. County MD Calvert | | . Town or Lo | Beach | | | | 10d. Inside City Limits 1 □ Yes 🛣 No |
| | th with the | ۵ | 10e. Street and Number 4010 BAND SHELL CT | | | 10f. Zip Code 20732 | 2 | | g. Citizen of What C | ountry? |
| 980 | d within 72 hours after death with the Maryland Jiene. I than "naturel", or items 23a or 28a-f ehow Itta Medical Eventinat must be notified at | by Fur | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: | | Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No | ispanic Origin? (Spe in, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Wh Specify: WI | ite, etc. |
| Maryland 21215-0036 | within 72 ane. than "nal | Completed | 15. Decedent's Ed (Specify only highest grad | cation fe completed) College (1-4or 5+) | (Give | DO NOT use retired | during most of work | ing | 6b. Kind of Business Oil Compar | · |
| land 2 | be filed ital Hyg id othe event, | To Be Co | 17. Father's Name (First, Middle, Last) Jules de Waele | | | | 18. Mother's Name | | laiden Sumame) | |
| | 12 7 14 17 | | 19a. Informant's Name/Relationship (7) Deborah Wahl Da | ypa, Print) aughter | | | | | City or Town, State, e Beach, 1 | |
| Baltimore, | of H | | 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Removal from State | emetery, cren | sition (Name of natory or other plac rematory | | | eoc.Location - City o | |
| Balt | permit. Pag Department Important: I eny injury o | | 21. Signar of Funeral Service Licens | MO1148 | 4 | 26 Crain | ral ^{Fa} Höme, Hwy SW, | Glen Bur | | 21061 |
| 8760, | Physician and with epicare percentage of the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the private and the p | ical Examiner | 23a. Part 1. Enter the disease or composition, or heart failure. Use only limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | ience of): Nover ience of): | | | | V linge | Approximate Interval Between Onset and Death |
| .O. Box 68 | The law requires that the death certificate has been signed by the attending place as should be detached for use as in | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de | death 3 | Ectopic pregnancy | | | 23d. Date of de Month | elivery Day Year |
| Δ, | w requires that I been signed by should be deta | þ | Part II. Other significant conditions or | ontributing to death but not resu | ulting in the u | nderlying cause give | en in Part I. | | | to the cause of death? |
| Vital Records, | | Completed | | | | | | 24a. Was an autopsy perform | 24b. Were a prior to death? | utopsy findings available completion of cause of s |
| Vita | Physician: Th this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital:atient 2 | ER/Outpatier | nt 3 DOA Oth | 26. Place of Deat er: 4 ☐ Nursing Ho | | nce 6 Other (Sp. | ecify) |
| Division of | ding After fune | Certification: T | 27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide 6 Could not be | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | Wor | | 28d. Describe hov | w injury occurred | |
| Divi | tal or Attenders after death | Certifi | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At ho building, etc. (Specify | me, farm, str | eet, factory, office | | 28f. Location (Str. City or Town, | eet and Number or F , State) | Rural Route Number, |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edicai | (Check only 2 Medical Examone) | ysician: To the best of my knowiner: On the basis of examinat and manner stated. | wledge, death tion and/or in | vestigation, in my o | pinion, death occur | red at the time, da | ite and place, and du | e to the cause(s) |
| | 5 Wilt | E | 29b. Signa/urle and title of certifian | (Harr | \checkmark | 29c. Licens | 14316 | 3 | Od. Date signed (Mor | S (Day, Year) |
| 1 | 71 | | 30. Name and address of person who of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o | completed cause of death (Item 200 32 Registrar's Signa | M | edical | Palwy | Anna | polis | MD 21401 |
| - 3 | Sta Regist | ate rar | NOV 2 9 200 | | Los | النالية | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:55a 11 23 2005 White Sylvia /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner 2700 Matthews Street Baltimore NA Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**只**F Yrs. 70 218-30-1515 Md. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ehow other traumatic event, the Madical Examinar must be notified at YYes 2 □No Funeral Director NA Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itema 23a or 2700 Matthews Street 21218 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Super Kids Warehouse Price Ticketer 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H Dunlap Simpson Perry ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2700 Matthews Street, Baltimore, Md. t Health Husband Leviticus White 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) ō = 5 Department of Important; If eny injury or once. 12 - 1 - 05Baltimore, Md. Greenmount Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. Women la March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chionic obstructive **Physician** Driwovach 1100 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို : After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building. etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier Resenthul 28,2005 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3414 St. Paul Street 21218 Baltimore, Md. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

| | | | For Stata Registrar | State of Ma | | partment of <i>Certificate o</i> | | d Mental Hygi | ene 2005 | 38292 |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------|--------------------------------------|----------------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| | Physici /Medic | | Decedent's Name (First, Middle, Las PHIL) | | | WHITFIE | LD | 2. Date of Death Month | Day Year ZZ ZX | 3. Time of Death 5 0 8 4 5 M |
| | Examir | | 4a. Facility Name (If not institution, give ST. Agnes | street and number) | a\ | 4b. City, Town | or Location of D | | 4c. County of Dea | th |
| | Funeral Director | | 225-56-2691 | x 7. Ag X M 2 ☐ F | e (In yrs. last birtho | Months Day | | Hrs. 8. Date of Birth (Month, Day, 4-9-4) | Year) Co | thplace (State or Foreign buntry) Va. |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town o | r Location | | | | 10d. Inside City Limits |
| | Mary e-f sh | tor | Md. NA | | Baltin | nor | | | | 1 ☐ Yes 2 No |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | ө | 10 | g. Citizen of What Co | ountry? |
| | s 23a | rai | 1430 Langford 1 | | | | 21207 | | USA | |
| 920 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, Ire M. dreil Exa. ritier is usite. Described at Once. | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates: | No | If Yes, specify C | | ? (Specify Yes or No- uerto Rican, etc.) | 14. Race - Ame Black, Whit | e, etc. |
| 5 | 72 ho | eted | 15. Decedent's Ed (Specify only highest gra | | 16a. De | ecedent's Usual Occive kind of work do | cupation ne during most of | working 1 | 6b. Kind of Business | Industry |
| 21215-0036 | l within iene. | Completed | Elementary/Secondary (0-12) 4th grade | College (1-4or 5 | 5+) | e. DO NOT use ret isabled | ired) | | NA | |
| 9 | al Hyg I othe vent, | Be C | 17. Father's Name (First, Middle, Last) | | | IDUDICA | 18. Mother's | Name (First, Middle, M | laiden Sumame) | |
| <u> </u> | ould b Menti arked | To | Sidney | Elijah | | field | Ma | | Bradley | |
| Maryland | d 2 sh h and 7 la m treum | | 19a. Informant's Name/Relationship (7 | _ | | | | Rural Route Number, | | |
| | Healt Healt tem 2 | | William Whitfield 20a. Method of Disposition | a Bro | 20b. Place of D | sposition (Name of | | , Baltimore | e, Md. 21 Oc. Location - City or | 207 Town, State |
| <u>o</u> E | Pages ent of nt: If i | | th☐Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | crematory or other p Mem Par | | -28-05 | Randallst | |
| Baltimore, | permit. Departm Importe any inju | | 21. Signature of Funeral Service Licen | | | 22. Name and Add | dress of Facility | Baltim | ore, Md. | 21202 |
| | 0. □ = e 0 | | 23a. Part1. Enter the disease, or comp | Warren |) I the death. Do not | March F. | | | North Ave | |
| Sec. State | Physician /Medical Examiner | | shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a. Athel | a consequence of): | 100 | | vesele | | Approximate Interval Between Onset and Death |
| | uted d ansit | Examiner | f any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to for as | a consequence of) | ļ | | | | V-1 |
| 8760, | ficate be executed physician and sthe burial-transit | ai Exa | resulting in death) Last | Due to (or as | a consequence of): | | | | | |
| ထ | tificate g phy as the | ledicai | | u. | | | | | | |
| .O. Box | The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal death | 3 □Ectopic pregnal 5 □ Other (specify) | | | 23d. Date of del Month | ivery Day Year |
| S, D | w requires that been signed b should be deta | by | Part II. Other significant conditions of | ontributing to death b | ut not resulting in th | e underlying cause | given in Part I. | | acco use contribute to | |
| I Record | | Completed | | | | | | 24a. Was an autopsy perform 1 Yes 2 | ed? prior to death? | topsy findings available completion of cause of |
| Vital | Physician: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | _ | Death (Check only one | | |
| | 문 두 등 | 1: 10 | 1 ☐ Yes 2 No 27. Manner of Death | 1 ☐ Inpatie | | LIGHT 3 DOA | | g Home 5 Resider | | cify) |
| on | Attending Ph r death. ector: After th by the funeral | ation | Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Da | y Year) Inju | ry V | Vork? ☐ Yes 2 ☐ No | 200. 20001120 1104 | williary occurred | |
| Division of | e Hospital or Attend 24 hours after death a Funeral Director; etely filled in by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injuding, etc. | ury - At home, farm c. (Specify) | street, factory, office | ce | 28f. Location (Stre City or Town, | eet and Number or Ru State) | ral Route Number, |
| | To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the | edicai | 29a. Certifier Check only one) Certifying Physical Exemption | ysicien: To the best of tiner: On the basis of and manner sta | f examination and/o | eath occurred at the r investigation, in m | time, date and play opinion, death o | ace, and due to the car ccurred at the time, da | use(s) and manner as te and place, and due | stated. to the cause(s) |
|) | with To t | M | 29b. Signature and title of certifier | 24 | fi . | 29c. Lice | ense number | | d. Date signed (Monti | |
| | 'n | | 30. Name and address of person who o | completed cause of d | leath (Item 23a) (Ty | pe, Print) | 2103 | ۷ ا | Honger thank | 0,000 |
| | Sta | At I | 31. Date filed (Month, Day, Year) | 32. Registra | ar's Signature | O Cato | on Aver | ove Bol | the stand | 2122 |
| | Registi | ar | NOV 2 9 | 2005 | wes & | Lower | | | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 38293 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death st Year Month **Physician** IAMS NOV H /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Lorren Muning and Rehabilitation Contr If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 5-23-12 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M XXF Yrs. 93 Director 240-52-7685 N.C. Usual Residence of Decedent filed within 72 hours efter death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or fams 23a or 28a-f ahow the Medical Examiner must be notified at 11√2 Yes 2 No Director Md. NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 W. Franklin Sreet 21201 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Black Š 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry markad other than Elementary/Secondary (0-12) College (1-4or 5+) end Mentel Hygiene. Laundry 8th grade 17. Father's Neme (First, Middle, Last) Stella Maris 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Peges 1 and 2 should be Department of Health and Mentel ۵ Robert Thomas Belle Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Health em 27 l 1921 Old Warsaw Road, Clinton, N.C. George Barnett Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 돌청 11-29-05 Trinity Cem. Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 la Warre March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** COROHORY AMERY DISEASE Immediate Cause (Final disease or condition resulting in death) /Medical Years Examiner Due to (or as a consequence of) by Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uriknown Cerebrory whom areclant A trial fibrilation 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificete hes 10 765 2LNo 1 ☐ Yes 2 ☐ No Physician: within 24 hours efter deeth.

To the Funeral Diractor: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury edical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) disharm D 0053411 05 NOV

DHMH 16 Rev 6/95

State

Registrar

14300

31. Date filed (Month, Day, Year)

Bome

210

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gallant Fox Ln

NOV 2 9 2005

shesain

20715

Bernard Woodard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 7945State of Maryland / Department of Health and Mental Hygiene ALK Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 25, 2005 **Physician** 7:39 A M 1000 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Northwest Hospital Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Days Hours 227-68-374 Director 10b. County 10c. City Jown or Location 10d. Inside City Limits 10a. State injury or other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? ō 238 21133 Race - American Indian, Black, White, etc. or itema 11. Marital Status 12. Was Decedent Armed Forces' Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 Ño ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than College (1-4or 5+) condary (0-12) ges 1 and 2 should be filed with it of Health and Mental Hygiene. If item 27 le merked other ther Seneral 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Midple, Maiden Sumame 19a. Informant's Name/Relationship (Type, Print) mD 21/33 naritin 100 Nowwo 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State matory or other place) Pages Burial 2 Cremation 3 Removal from State permit. Page Depertment c Importent: If any injury or once. Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) cardioverseular desper **Physician** Huperlensive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physicien detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ⅓ Yes 2 □ No 24a. Was an autopsy perform this certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 XYes 2 No Other: 4 Nursing Home 5 Residence 1 | Inpatient 2 ER/Outpatient 3 □ DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Diractor: After Division 1 Naturat 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland former B. Southall MT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2005 Registrar

| | | | 1- State of Maryland / E | Department of Health and Certificate of Death | d Mental Hygier | 40 40 | 38295 |
|------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------|-------------------------------------------------------|
| | Physici | an i | Decedent's Name (First, Middle, Last) | | 2. Date of Death | Day Year | 3. Time of Death |
| | /Medic | al | William Walker, J 4a. Facility Name (If not institution, give street and number) | Y . 4b. City, Town, or Location of D | November | 24, 2005 4c. County of Deat | |
| - 6 | Examin | C1 | Liberty Nursing & Rehabilitation C | , | Ball | · | /A |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last bin 219−16−5896 1 □XM 2□ F 80 | thday) If Under 1 Year If Under 24 | vin. (Month, Day, Yea | ar) 9. Birtl | Maryland |
| | ow ow | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | n or Location | | | 10d. Inside City Limits |
| | he Mary 28a-f eh | Director | Maryland N/A | Baltimore | | Citizen of What Co | 1√ Yes 2 No |
| | 3a or | i Dir | 4017 Liberty Heights Avenue | 21207 | 109. | USA | artity. |
| 36 | 72 hours after death with the Maryland Insturel; or Items 23s or 28s-f ehow Usel Examiner must be multied at | by Funerai | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P | ? (Specify Yes or No- uerto Rican, etc.) | 14. Race - Ame Black, White | |
| 21215-0036 | S 2 | Completed to | | Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) | working 16b | . Kind of Business/ | Industry |
| 121 | illed with If Hygiene. other ther | | | Longshoreman | Name (First, Middle, Maid | | Shipping |
| anc | d be entai ked c | To Be | William Walker | | ittie Johns | · | |
| Maryland | and M | | 19a. Informant's Name/Relationship (Type, Print) | . Mailing Address (Street and Number o | r Rural Route Number, Cit | ty or Town, State, 2 | |
| | s 1 and 2 if Health Item 27 I | | | 5430 Park Heigh | | t. 404 Location - City or | |
| nor | of of or | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State | ry, crematory or other place) | | | |
| Baltimore, | permit. Pag Department Importent: any injury c | | 21. Signatury of Fureral Septice Licensee Edward A. Gregorchik | Crematory, Inc. 1 22. Name and Address of Facility 299 Frederick Ro | Cremation Se | ociety of | MD, Inc. |
| | 春 変 | | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. | | | <u> </u> | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) A Delew | | | | Onset and Death |
| 20. | /Medical Examiner | | Due to (or as a consequence | of): | | | 2.8 |
| L. | | ner | Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury | of): | | | 1 |
| X | and and I-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last C | of): | | | |
| 8760, | ate be executed hysicien and the burial-transit | | d | , | | | |
| Box 6 | ne death certific the attending p hed for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 □Ectopic pregnancy 5 □ Other (specify) | | 23d. Date of del | ivery Day Year |
| rds, P.O | quires that the signed by all be detacted | b | Part II. Dther significant conditions contributing to death but not resulting in | n the underlying cause given in Part I. | 23e. Did tobacc | | the cause of death? |
| I Records, | The ate h page | Completed | | | 24a. Was an autopsy performed | prior to death? | itopsy findings available completion of cause of 2 No |
| Vital | Physicien: The this certificate ral director, page | Be | 25. Was case referred to medical examiner? | 1 Out // | Death (Check only one) | | |
| of | Phys this al di | .: To | 27. Manner of Death 28a. Date of Injury 28b. | Time of 28c. Injury at | ng Home 5 Residence | | cify) |
| ion | Attending in death. | atio | 2 Accident investigation | Injury Work? M 1 ☐ Yes 2 ☐ No | | | |
| Division | ospital or Attend hours after death unerel Director: ly filled in by the | Certification; | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify) | arm, street, factory, office | 28f. Location (Street City or Town, St | | ural Route Number, |
| | To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer | edical C | 29a. Certifier (Check only one) 1 | | | | |
| | To the within To the comp | Me | 29b. Signature and title of certifier | 29c. License number | 29d. No | Date signed (Monti | 5. 2005 |
| • | 3 | | 30. Name and address of person who completed cause of death (Item 23a) | (Type, Print) The try Bel. | Root ona | 2/12 |) |
| - | St | ate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | not organ. | aco in | 0110 | , |
| | Regist | rar | NOV 2 9 2005 Server & | pole | | | |

Certificate of Death

2. Date of Death

38296

3. Time of Death

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

| hysici /Medic | | | THINGTON- | | | Month | 3 · 2005 | Year 10:30 AM |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Examin | 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death Abstraction of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death Accounty of Death | | | | | | | |
| uneral rector | | RAL. 68.1105 | . Sex 7. Ag | ge (In yrs. last birthday) 58 Yrs. | | Min. (Month, | | Birthplace (State or Foreign Country) NC |
| Important: If item 27 is marked other then "naturel", or items 23a or 28e-f ehow any injury or other traumatic event, it a Medical Examinat must be notified at once. | Funeral Director | Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number QDI OAKDALE C | URCLE | 10c. City, Town or Lo | | | 10g. Citizen of WI | |
| urel', or items : | þ | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | If Yes, Give Year or Dates: | ? No | Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 1 Yes 2 No Specify | an, Puerto Rican, etc.) | No- 14. Race Black | - American Indian, , White, etc. |
| other then "nat ent, the Medica | e Completed | 15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12 14 GRADE 17. Father's Name (First, Middle, La. | completed) College (1-4or 2 YRS | (Give life. | dent's Usual Occupation kind of work done during m DO NOT use retired) ERNISOR 18. Mol | ost of working ther's Name (First, Mid | UNIVERS | IN OF MD |
| is marked o aumatic eve | To Be | ANTHONY WETHI | (Type, Print) | | LILLIng Address (Street and Num | E MAE EC | DWARDS mber, City or Town, S | tate, Zip Code) |
| nt: If item 27 ry or other tr | | LEO SPARKS, JR 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec | | 20b. Place of Dispo cemetery, crer | DAKDALE UR. sition (Name of matory or other place) J NAMONAL | Date | 20c. Location - C ARUNGIO | city or Town, State |
| Importa any Inju once. | | 21. Signature of Funeral Service Lic | ensee | VÃ | Name and Address of Facture HIVE GRESS BAUD. NATU | ENE FUNER | AL SERVICE | |
| sician edical miner | Iner | 23a. Part. Entier the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | a. Breas Due to (or as | 1 0 | | as cardiac or respirator | y arrest, | Approximate Interval Between Onset and Death |
| ettending physicien and for use as the burial-transit | dical Examiner | Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| 9 9 | ysician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | | 23d. Date Mont | of delivery h Day Year |
| To the Funerel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach | eted by Phy | Part II. Other significant conditions | contributing to death b | out not resulting in the u | nderlying cause given in Par | | / | oute to the cause of death? |
| tificete hes b tor, page 2 s | e Completed | 25. Was case referred to medical | 1 | | 26 Pla | 24a. W at pe 1 Ye ce of Death (Check on | ortopsy pri enformed? de s 2 2 No 1 | ere autopsy findings available or to completion of cause of ath? Yes 2 \(\sum \text{No} \) |
| is cer direct | To B | examiner? 1 Yes 2 No | Hospital: | ent 2 ER/Outpatier | Other | Nursing Home 5 R | | (Specify) DAUGHTERS H |
| octor: After they the state of the state of the funeral | Certification: | 27. Manper of Death 1 Matural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine | be 28e. Place of In | iy Year) Injury jury - At home, farm, str | 28c. Injury at Work? M 1 Yes 2 | 28d. Descrit | be how injury occurred | |
| Funerel Dire | | 29a. Certifier 1 Certifying F | Physicien: To the best aminer: On the basis o | of examination and/or in- | n occurred at the time, date vestigation, in my opinion, d | and place, and due to t | Town, State) he cause(s) and manner, date and place, an | ner as stated. |
| To the comple | Medical | 29b. Signature and title of certifier | and manner st | | 29c. License numbe | | 29d. Date signed (| 1 |
| (e) Sta | to | 30. Name and address of person wh | earns, M | death (Item 23a) (Type, 0 - 1650 0 rar's Signature | Print) (leans St. 1 | m53. Ba | Itimore p | ng 21231 |
| Registr Rev 1/2 | ar | | | I Ago | refer | | | |

Registrar

| Dominiqu 05-07751 | e Donte | Walker |
|----------------------|-----------------------|------------------------------|
| crn | | 1 - For State Registra |
| | SH. W. W. | 1. Decedent's |
| | Physician /Medical | Domin |
| | Micaicai | |

| 1). | L | | For State Registrar | State of Maryla | | artment of H rtificate of | | | giene Reg. Xo. 0 | 15 (| 38297 |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------|-----------------------------------------|-------------------------------|-------------------|---------------------|----------------------------------------------------------|------------------------------------------|
| | S SKEW | | 1. Decedent's Name (First, Middle, Las | t) | | | | 2. Date of Dea | ath Day | Year | 3. Time of Death |
| | Physicia /Medic | | Dominic Donte' Wa | lker | | | | Novembe | | 2005 | 1:25 A ^M |
| 4 | Examin | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, o | or Location of Death | | 4c. County | y of Death | |
| | * | . W | 2132 Alice Avenue, 5. Social Security Number 6. S | Apartment 1 | 04 vrs. iast birthday) | Oxon E | if Under 24 Hrs. | 8. Date of Birt | | e Geo | rge's |
| 7 | Funeral Director | | | 12 M 2 □ F 26 | Yrs. | Months Days | | June 1 | , 1979 | Wash | ington DC |
| | 0 | | Usual Residence of Decedent | | | | | | | | |
| | arylar ehow | Ľ. | 10a. State 10b. County | | City, Town or Lo | | | | | 11 | 0d. Inside City Limits 1 □ Yes 2 □ No |
| | the M | Directo | District of Columb | ola Wa | shingto | n 10f. Zip Code | | | 10g. Citizen of | What Coun | 1 ☐ Yes 2 ☐ No XX try? |
| | with Sa or | וַם | 1362 "F" Street M | 1.E. | | 20002 | | 1 | United | | • |
| | ms 2; | Funeral | 11. Marital Status | 12. Was Decedent Ever i | n U.S. 13. | Was Decedent of I | Hispanic Origin? (Sp | ecify Yes or No | - 14. Ra | ce - Americ | an Indian, |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If tiam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinal must be notified at once. | þ | PANever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 XNo If Yes, Give Year or Dates: | | 1 ☐ Yes 2 🕅 No | Specify: | nican, etc.) | | ck, White, of Bla | |
| 9 | 72 ho natur | Completed | 15. Decedent's Ed (Specify only highest gra | | (Give | dent's Usual Occup kind of work done | during most of work | ing | 16b. Kind of B | Business/Ind | lustry |
| 12 | within | mpi | Elementary/Secondary (0-12) Twelth | College (1-4or 5+) | | DO NOT use retire ployed | id) | | | NT | |
| 5 5 | Hygie Hygie other ant, III | ပိ | 17. Father's Name (First, Middle, Last) | | onem | proyed | 18. Mother's Nam | e (First, Middle, | Maiden Sumar | None | |
| <u>a</u> | td be ental ked o | To Be | Calvin Fredericks | | | | Rose W | alker | | | |
| ary | should and Men marke | - | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Maili | ng Address (Street | t and Number or Rur | al Route Numbe | er, City or Town | , State, Zip | Code) |
| Σ, | and 2 ealth a n 27 is | | Rose Fredericks/M | | | | et N.E. W | ashingt | | | |
| Baltimore, | Pages 1 nent of Hi int: if itar iry or oth | | 20a. Method of Disposition 13 Burial 2 Cremation 3 | Removal from State | * | matory`or other pla | LOVER | ber 23, | 20c. Location | - City or To | wn, State |
| 를 | permit. Page Department of Important: If any injury or once. | | 4 ☐ Donation 5 ☐ Other (Specifical Service Licenters) | , | | Cemeter | y 2005 ess of Facility Rob | ert G. 1 | Washin Mason F | gton | DC 1 Home |
| Ba | Depa Impo any i | | 21. Signature of Pulleral Service Elder | 1 | | | Hope Rd S | | | | |
| | | | 23a. Part1. Enter the disease, or com- shock, or heart failure. List only | plications that caused the cone cause on each line | leath. Do not en | ter the mode of dy | ing, such as cardiac | or respiratory ar | rrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Mustro | 10 (315 | u shot W | ounds a | wa BI | unt | | Onset and Death |
| 184 . 27 | /Medical Examiner | | resulting in death) | Due to (or as a con | sequence of): | Force + | ounds a tead In | xuvies | | | |
| -Pax - | Examiner | _ | Sequentially list conditions, | b | | | - | 3 | | | |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | 304201100 017. | | | | | | |
| 8760, | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | | resulting in death) Last | Due to (or as a con | sequence of): | | | | | | |
| 687 | ificate g phys as the | Physician/Medical | | d | | | | | | | |
| Box | that the death certific ed by the attending p detached for use as | an/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pre | | ⊒Ectopic pregnanc | ev | | | ate of delive | |
| | e deal | sicis | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 4 ☐ Pregnant at time 9 ☐ Unknown | | Other (specify) | | | M | onth | Day Year |
| P.O. | hat th od by i | | Part II. Other significant conditions of | ontributing to death but not | resulting in the u | inderlying cause or | ven in Part I. | 23e. Did to | obacco use con | tribute to th | e cause of death? |
| Division of Vital Records, | w requires that been signed be should be det | d by | | , | • | ·····,···g -··· g | | 101 | Yes 200 No | 3 ☐ Prob | ebly 4 Unknown |
| COL | s beer shou | Completed | | | | | | 24a. Was | | Were auto | psy findings available |
| Re | The lay ate has page 2 | ошо | | | | | | autop perfo | rmed? | prior to cor death? 1 \(\frac{1}{2} \text{Yes} \) | npletion of cause of |
| ita | sician: Th certificate rector, pag | Be C | 25. Was case referred to medical | | | | 26. Place of Deal | // | | 7 | |
| <u>></u> | Physician: r this certificantal director, | To | examiner? 1 ☑¥es 2 ☐ No | | 2 ER/Outpatie | III 3 DOA | | me 5 Resid | | her (Specify | , at scene |
| n c | ding P h. After t funera | lon: | 27. Manner of Death 1 □Natural 5 □ Pending | 28a. Date of Injury (Month, Day Yea | 28b. Time of | . Wo | ork? V | 28d. Describe I | | rred Saul | ted |
| isic | l or Attending after death. Director: After I in by the funer | flcat | 2 Accident Investigation 3 Suicide 6 Could not b | e 290 Place of Injury | At home, farm, st | | | 28f. Location (| Street and Num | | I Route Number, |
| <u>S</u> | al or A safter il Direct d in by | Certification: | 4 Homicide | building, etc. (Sc | pacify) | 1 1 0 | 4 | City or To | wn, State) 2 | 327 | SICO AVE |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Medical (| | nysician: To the best of my niner: On the basis of exar and manner stated. | | | | | | | |
| | ro the vithin ro the | Me | 29b. Signature and title of certifier | | | 29c. Licen | ise number | | 29d. Date signe | ed (Month, | Day, Year) |
|) | 2 | | · Caroli | tallan | md | 0 | .C.M.E. | | Novembe | er 17, | 2005 |
| r | 1 | | 30. Name and address of person who | completed cause of death | | | | | | | |
| 0 | ~ | | 31. Date filed (Month, Day, Year) | 32. Registrar's S | | 1 Penn S | treet, Ba | Ltimore, | , Maryla | and 21 | L201 |
| | Sta Regist | | | A | rgriatul u | | | | | | |
| DH | MH 17 Rev 1/2 | | NOV 2 9 20 | 85 Marie | N A | and o | | | | | |
| | | | | • | ORIGII | VAL | | | | | |

| | 1 - For State Registrar | | State of M | aryland / | Depart Certi | ment of I | Health a | and Me | | giene Reg. No. | 005 | 38298 |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------|--------------------------------|------------------------------|----------------------------------------------------|-------------------------------|------------------------------|--------------------------------|--------------------------|------------------------------------|----------------------------------------------------|
| Physicia /Medica | -111111 | rst, Middle, Last) | TONES | WAS | SHIN | 19 Tor | V | | Date of Dea Month | Day. | th Year 4 2005 | 3. Time of Death |
| Examine | 4 - 22 - 51 - 44 | JEST I | HOSPITA | (CG | ITER | b. City, Town, o RAN f Under 1 Year | DALL | STOV | Date of Birth | | Ounty of Death | MORE |
| Funeral Director | 169-34-473 Usual Residence of Dec | 0 1 - | M 2 🗓 F | 64 | | onths Days | | Min. | (Month, Day | /, Year) | Cour | place (State or Foreign http) "H CAROLINA |
| death with the Maryland ms 23a or 28a-f show | 10a. State 10 | b. County | | 10c. City, To | wn or Locat | | | | | | 1 | 0d. Inside City Limits 1 √ Yes 2 □ No |
| with the | 10e. Street and Number | | T APT 9: | | | 10f. Zip Code 2121 | .7 | - | | 10g. Citize | en of What Cour | ntry? |
| | 11. Marital Status 1 Never Married 3 Widowed 4 | 2 Married | 2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give | | If Y | s Decedent of I | an, Mexican | gin? (Specif , Puerto Ric | y Yes or No- an, etc.) | | Race - Americ Black, White, | etc. |
| within 72 hours after ene. then "naturel; or its he Medical Examine | 0 15. | Decedent's Educ only highest grade | Year or Dates: eation completed) College (1-4or: | | (Give kin | t's Usual Occu d of work done NOT use retire | durina most | of working | | 16b. Kind | of Business/In | dustry |
| and LI | 12th grade 17. Father's Name (Firs | е | 1 yr | | RIVAT | E DUTY | | | First, Middle, | HEAL Maiden St | | |
| laryland 4.14. 2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Ins M. | CAROLINA 19a. Informant's Name | | | 19 | 9b. Mailing A | Address (Street | | | LE ANTI | - | Го w п, State, Zip | Code) |
| Te, IV Tand Health Health tem 27 other tr | Tamra Wash 20a. Method of Disposit 1XX9urial 2 □ C | ion | | 20b. Place | of Dispositi | 9 MADIS on (Name of ory or other pla | | ENUE Date | | | MARYLA | ND_21217 own, State |
| Dallimo permit. Pages Department of Importent: If I any Injury or o | ° 4 □ Donation 5 □ 21. Signature of Juneta | Other (Specify) | | WOOD | 22. N | CEMETER ame and Addre LIAM C | ess of Facility | 2-01-0 COMMU | | | 'IMORE, | MARYLAND , P.A. |
| | 23a. Part : Enter the d | isease, or complications. List only on | cations that caused e cause on each li | d the death. De | | 6 W NOR he mode of dyi | | | espiratory arr | rest, | | Approximate Interval Between Onset and Death |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | al Ca. | Due to (or as | a consequenc | SEPS e of): | SIS | | | | | | Onset and Death |
| | Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or hi). | ons, b. diate g | | a consequenc | e of): | | | | | | | |
| De Be | if any, leading to immercause. Enter Underplace that initiated events resulting in death) Last | c. d. | | a consequenc | e of): | | | | | | | |
| The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the | IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 No. 9 Unknown | ignant iths? | 3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown | 2 Fetal dea | | topic pregnanc ther (specify) _ | у | | | 230 | d. Date of delive Month | ory Day Year |
| w requires that to been signed by should be detail | | | tributing to death b | | | rlying cause gr | | | 23e. Did to | | _ | ne cause of death? |
| VICAL INCCO | REPLACE: | MENT | PANS | INVSM | S | | | | 24a. Was a autops perform | sy | | psy findings available npletion of cause of |
| lysicien: T | 25. Was case referred examiner? 1 Yes 2 No | | ospital: | ent 2 ER/0 | Dutpatient | 3□ DOA O# | nor. | | 5 🗌 Reside | | □Other (Specify | () |
| | 27. Manner of Death 1 Matural 5 2 Accident | ☐ Pending investigation ☐ Could not be | 28a. Date of Inju (Month, Da | ıry 28b <i>y Year)</i> | . Time of Injury | 28c. Inju Wo M 1 | ryat rk?]Yes 2∐N | No | . Describe h | | | |
| itel or Att | 3 Suicide 6 4 Homicide | determined | 28e. Place of In building, et | ury - At home, c. (Specify) | farm, street | factory, office | | 28f. | City or Town | treet and h n, State) | Number or Rura | I Route Number, |
| the Hosp in 24 hou the Fune pletely fil | 29a. Certifier 1 (Check only one) | Certifying Phys Medical Examin | ician: To the best er: On the basis o and manner st | f examination a | ge, death oo and/or inves | curred at the ti | me, date and opinion, deat | d place, and h occurred a | due to the c at the time, d | ause(s) an ate and pl | nd manner as st ace, and due to | ated. the cause(s) |
| To with To Com | ≥ 29b. Signature and title | of certifier Rauge | najour |) NI |) | 29c. Licens | 428 | 8 | 2 | 19d. Date s | signed (Month, s | Day, 15ear) 242005 |
| 5 | 30. Name and address | Any I | RAN C | death (Item 23a | (Type, Pri | 11) NB | regine | of thy | Spile | Ple | ulg | |
| Stat Registra | | 2 9 2005 | RAN C | ar's Signature | Garle | 9 | | | | | | |

| | | 1 - For State Registrar | State o | of Marylan | | artment of F | | d Mental Hy | giene Reg. No. | 005 | 38299 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------|----------------------------|--------------------------------------------|------------------------|---------------------------------------------|------------------|-----------------------------|---------------------------------------|---------------------------------|----------------------------------------------------|
| Dhuoi | iaian | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of De | eath Day | Year | 3. Time of Death |
| Physi /Med | dical | Charles Matt | | | | | | Novemb | er 25 | 5, 2005 | 11:45 A.M |
| Exam | niner | 4a. Facility Name (If not institution, giv 22 Cu1more Court | e street and nu | ımber) | | 4b. City, Town, o | | ath | 4c. | County of Death | |
| F | | 5. Social Security Number 6. S | ex | 7. Age (In yrs. | last birthdav) | Luther 1 Year | | rs. 8. Date of Bi | rth | Balti | |
| Funera Directo | | | XM 2□F | 93 | Yrs. | Months Days | Hours M | in. (Month, D | ay, Year) | | nplace (State or Foreign untry) cvland |
| b • | | Usual Residence of Decedent 10a, State 10b, County | | 10a Cib | y, Town or Lo | | | | | | |
| Aaryla Fahov ed at | 'n | Maryland Baltim | ore | | Luther | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| 28a-1 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citiz | zen of What Co | |
| h with | D E | 22 Culmore Cour | + | | | 21093 | · | | | IISA | |
| deati | Funeral | 11. Marital Status | | cedent Ever in U. | | | ispanic Origin? | (Specify Yes or No | 0- 1 | 14. Race - Amer Black, White | |
| s after | y Fu | 1 Never Married 2 Married | 1 ☐ Yes If Yes, G | 2/No ive | | I ☐ Yes 2/□kNo | Specify: | 3113 1 113411 31317 | | Specify: Whi | • |
| 72 hours a "natural", o | ed by | 3 Widowed 4 □ Divorced 15. Decedent's E | Year or I | Dates: | 16a Decer | ient's Usual Occup | ation | | | nd of Business/l | |
| nin 72 Medic | Completed | (Specify only highest gra | ade completed) | (1-4or 5+) | (Give | kind of work done OO NOT use retired | durina most of v | vorking | TOD. KII | id or Edsiriesavi | noustry |
| d with | l e | 8 | | | | Superviso | r | | Ge | eneral M | lotors |
| VIGITION And be file Mental Hy arked oth | Be | 17. Father's Name (First, Middle, Last, Orvilton |) Wilhelm | • | | | | lame (First, Middle | | , | |
| ryica hould d Mer marke | 은 | 19a. Informant's Name/Relationship (| | | 19b Mailie | a Address (Street | | arl May Rural Route Numb | | | in Cada) |
| Man od 2 st lith and 27 is n traun | | Kathy Hammel | Niece | | 13D. Maili | | | | | | and 21093 |
| S 1 ar | 1 | 20a. Method of Disposition | | 1 0 | Lace of Dispo | sition (Name of natory or other place | 1 | Date | | cation - City or T | |
| Page Page nent o | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif | | State Mt. | . Pleas | sant Ceme | tery11/ | 29/2005 | Gamb | er, Mar | yland |
| DEILITIOFE, INITY STATE A LA 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23e or 28e-f ahow any injury or other traumatic avant. It a Modical Examination must be notified at | 90 | 21. Signature of Funeral Service Licer | 1500 | | 22 B1 | . Name and Addre | ss of Facility | z Eupopo | 1 Цст | o T== | 21211 |
| | ā | Tym 19 | · Hen | 33) | 36 | od ralls | Road. | z Funera Baltimore | , Ma | ryland | 21211 |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | one cause on | each line. | | er the mode of dyin | g, such as card | iac or respiratory a | arrest, | | Approximate Interval Between Onset and Death |
| Physicia /Medica | _ | Immediate Cause (Final disease or condition resulting in death) | a | DEMEN | | | | | | | YEARS |
| Examine | | | Due to | (or as a consequ | uence or): | | | | | | |
| | ne. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to | (or as a conseq | uence of): | | | | | | |
| acuted ind transi | Examine | Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | | |
| law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | E | resulting in death) Last | Due to | (or as a consequ | uence of): | | | | | | |
| physicate sthe | dlcal | • | . d | | | | | | | | |
| wrequires that the death certifications igneed by the attending I should be detached for use as | n/Me | IF FEMALE: 23b. Was decedent pregnant | | tcome of pregna | | 1 . | | | 2 | 3d. Date of deliv | /ery |
| death death | hysician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No | | birth 2 Fetal | | Ectopic pregnancy Other <i>(specify)</i> | <u> </u> | | | Month | Day Year |
| at the the top the stache | Phys | 9 Unknown | | | | | | | | | |
| res th | by | Part II. Other significant conditions of | antributing to c | death but not resi | ulting in the ui | nderlying cause giv | en in Part I. | | tobacco us Yes 2 [| _ | the cause of death? bably 4 XUnknown |
| law requires t as been signe | etec | | | | | | - | - | | | |
| VITAL DEC sician: The law scertificate has b lirector, page 2 s | ompleted | | | | | | | | psy ormed? | prior to co death? | opsy findings available ompletion of cause of |
| VICIAN: TI ician: Ti certificate ector, pa | ပိ | 25. Was case referred to medical | | | | | 26 Place of F | 1 ☐ Yes eath (Check only | 2 100 | 1 🗆 Yes | 2 No |
| Of VILA Physician: rthis certific ral director, | To B | examiner? 1 □ Yes 2X No | Hospital: 1 🗆 | Inpatient 2 🗆 | ER/Outpatien | t 3 DOA Cth | 00 | Home 5 Resi | | □Other (Speci | ify) |
| ding Phys | | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date (Mor | of Injury oth, Day Year) | 28b. Time of Injury | 28c. Injur Wor | y at k? | 28d. Describe | how injury | occurred | |
| Vitanding death. | catl | 2 Accident investigation 3 Suicide 6 Could not b | | 71.1 | , | | Yes 2□No | 20/ 1 | · · · · · · · · · · · · · · · · · · · | | 10 |
| INISION or Attanding after death. Diractor: Afte | Certification: | 4 Homicide determined | 200. Plac | e of Injury - At no ling, etc. (Specif) | me, tam, str | eet, factory, office | | City or To | | Number or Hui | al Route Number, |
| DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | | 29a. Certifier 1 Certifying Ph | ysician: To th | e best of my kno | wledge, death | occurred at the tin | ne, date and pla | ice, and due to the | cause(s) | and manner as | stated. |
| ha Ho n 24 t he Fu pletely | edical | (Check only 2 Medical Exar | niner: On the t and mar | pasis of examina nner stated. | tion and/or inv | restigation, in my o | pinion, death oc | curred at the time, | date and | place, and due t | to the cause(s) |
| To th To th | ž | 29b. Signature and title of certifier | 01. | 400 | | 29c. Licens | | | | signed (Month, | |
| T | | 1,000 | 091 | / ソソ | _ | CO | 7625 | | 11/7 | 18/05 | |
| 10 | | 30. Name and address of person who | complete cau | se of death (Item | 23a) (Type, | Print) TOWSON | IIMO | 21201 | 1 | RICHA | ROOMAllering |
| l S | State | 31. Date filed (Month, Day, Year) | | Registrar's Signa | | | 7.77 | | 1 | 4 - v = (1 · 7) | · · · · · · · · · · · · · · · · · |
| Regi | | NOV 2 9 21 | 05 | aug 1 | " Aga | 34(2) | | | | | |

DHMH 17 Rev 1/2001

Registrar

NOV 2 9 2005

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 24 **Physician** 2005 Kenneth Edward Willey 10:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Multi-Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Oct 13, 1915 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 10X M 20 F 90 Massachusetts Yrs. 579-07-7206 Director Usual Residence of Decedent the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12378 Greenspring Ave. U.S.A. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel", or Iten any injury or other treumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ If Yes, Give Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Steven A. Willey Bernice May Sederquest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12378 Greenspring Ave. Owings Mills, Md. 21117 Aida C. Willey - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Dec. 1,2005 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular accident-acute Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cerebravasenter disease Years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: - PSI 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ selvulation. flu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of death? certificate has autopsy performed 1 ☐ Yes 2 ☑ No 20 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours aft e Funerel Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hos within 24 ho To the Fun completely 1 (Check only one) 29d. Date signed (Month, Day, Year) D13657 gregor 7) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REPRESON, 700 W. + (700 W- 40 H STREET, BALTIMORE, VID 21211 32. Registrar's Signature State NOV 2 9 2005 Registrar

| Terre11 | | 11: | iams Impord T. Please Ty | pe or Print in B | lack ind | elible_lr | ık. Ensure | AIL Copies | Are Le | egible. | |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------|--------------------------------------|-----------------------------------|-----------------------------|-----------------------------------------------|
| AKG | , | | Unpend Items: 23 | /pe or Print in B a part I & II State of Maryland | | | | Mental Hy | giene | 105 | 38302 |
| | | X F | Registrar 1. Decedent's Name (First, Middle, Last) | | Cen | iticate d | of Death | 2. Date of De | Reg. No. | | 3. Time of Death |
| | Physici | | Terrell Y. Willia | lms | | | | Novemb | Day | 2005 | 2:04 A M |
| | /Medic Examir | | 4a. Facility Name (If not institution, give str | | | 4b. City, Tow | m, or Location of Dea | | | unty of Death | |
| 50 | | 1/4 | Bon Secours Hospita 5. Social Security Number 6. Sex | 7. Age (In yrs. Id | et hirthday) | Balt If Under 1 Yo | imore | S. 8 Date of Bi | rth | N / | pface (State or Foreign |
| 00 | Funeral Director | | | M 2XF 44 | Yrs. | | ays Hours Min | | 1961 | Cou | MD |
| 3 | and the | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Loc | ation | | | | | 10d. Inside City Limits |
| | the Marylan 28a-f show rolllied at | ctor | MD N/A | I | 3a ltir | nore | | | | | 1 ∑ Ýes 2 ☐ No |
| | with the | Funeral Director | 10e. Street and Number 4101 Mountwood R | Road | | 10f. Zip Cod | 21229 | | 10g. Citizer | of What Cou | intry? |
| | er death Itema 23 | nera | | 2. Was Decedent Ever in U.S Armed Forces? | S. 13. W | as Decedent | of Hispanic Origin? (Cuban, Mexican, Pue | Specify Yes or N rto Rican, etc.) | 0- 14. | Race - Amer Black, White | |
| 36 | of a | by Fu | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: | | ☐ Yes 2 🔀 | | , , , | | | ack |
| 2-00 | n 72 hours "natural" volcel Ex | | 15. Decedent's Educa (Specify only highest grade | ation completed) | 16a. Decede | ent's Usual Or | ccupation one during most of wo stired) | orking | 16b. Kind | of Business/Ir | ndustry |
| 21215-0036 | e filed within al Hygiene. I other than 'vent, tre Mu | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | lite. D | Casi | | | | Reta | il |
| nd 2 | be filed ital Hyg d other event, | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | ame (First, Middle | | , | |
| Maryland | d 2 should be th and Mental i? ie marked (traumatic ev | ٩ | MIIIE E. WIIIIQV 19a. Informant's Name/Relationship (Type | | 19b. Mailing | Address (St | GCVH reet and Number or F | | NI ISO | | p Code) |
| , M | and 2 ealth a n 27 ie | | Gortrude Williams | | A CONTRACTOR OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH | Mount | | - Andrews | | MD 2 | 21229 |
| nore | ages 1 nt of H I: If Iter | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re | moval from State | ace of Disposemetery, crem | atory or other | | Date 26 | | tion - City or T | WM MD |
| Baltimore, | permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie any injury or other trau QDCE. | | 4 □Donation 5 □Other (Specify) 21. • ig ature of Funeral Service Licensee | | | | ddress of Facility Greene T | | | | |
| <u> </u> | 20558 | | 23a. Part Enter the disease, or complica | ations that asysod the death | | | | | | alto. M | D 21229 Approximate |
| | Physician | | shock, or heart failure. List only one Immediate Cause (Final | ations that caused the death cause on each line. Atheroscle | | | | | arrost, | | interval Between Onset and Death |
| | /Medical Examiner | | disease or condition resulting in death) | Due to (or as a consequ | uence of): | | | | | | |
| | 7 8. | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ | iance of). | | | | | | |
| _ | xecuted and Il-transit | xaminer | Cause (Disease or injury that initiated events c. resulting in death) Last | Due to (or as a consequ | ience of): | | | | | - | |
| Box 68760, | eath certificate be e. attending physicien for use as the buria | cal E | d. | | · | | | | | | |
| x 68 | ertifica ding ph | /Med | IF FEMALE: | sc. If yes, outcome of pregna | ncv | | | | | I. Date of deliv | |
| P.O. Bo | The law requires that the death certificate be e. ate has been signed by the attending physicien page 2 should be detached for use as the burial | Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 承∪nknown | 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | death 3 🗌 | Ectopic pregn Other (specif | | | 230 | Month | Day Year |
| | res that the de signed by the a I be detached f | by Ph | Part ff. Other significant conditions cont Liver Cirrhos | | | | e given in Part I. | | | | the cause of death? |
| ord | w requir been si should I | | | 10. 011101110 11 | cpacre | | | 1 | Yes 2□1 | | |
| Rec | The law te has l age 2 s | Completed | | | | | | auto | opsy ormed? 2 \(\sum \) No | prior to co death? | opsy findings available ompletion of cause of |
| ita | ian: T | BeC | 25. Was case referred to medical examiner? | | | | | eath (Check only | | 785 103 | |
| of V | Physician: r this certific ral director. | ုင္ | 1 XX es 2 □ No | | ER/Outpatient | | | Home 5 Res | | | ify) |
| uo | nding F th. :: After e funera | atlon | 27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | M 200. | Injury at Work? 1 ☐ Yes 2 ☐ No | 280. Describe | now injury o | ccuriou | |
| Division of Vital Records, | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At ho building, etc. (Specify | ome, farm, stre | et, factory, of | fice | | (Street and Nown, State) | lumber or Ru | ral Route Number, |
| | Hospit 24 hours Funeral letely fille | Medical C | | ician: To the best of my kno ler: On the basis of examina and manner stated. | | | | | | | |
| | To th within To th comp | Me | 29b. Signature and title of certifier | d_ | | | cense number | | | igned (Month | |
| | | | ▶ Webl_ | | | | .C.M.E. | | Nove | nber 22 | 2, 2005 |
| | | | 30. Name and address of person who cor | | | | n Street, | Baltimor | e, Mai | cyland | 21201 |
| Υ., | St Regist | ate trar | 31. Date filed (Month, Day, Year) NOV 2 9 20 | 32. Registrar's Signa | ture | boils | | | | | |

State of Maryland / Department of Health and Mental Hygiene 38303 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:10 a Faye Rena Wolf NOV. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mount Airy Lorien Nursing Center Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Lary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 F 220-50-2553 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examinar mast be the titled at 1 ☐ Yes 2 No Manchester Director Carroll Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2581 Mindi Drive 21102 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Woodward Frances Bowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Dep. rtment of Health a Important: If item 27 Is any injury or other tre Wallace G. Wolf, Sr. - husband 2581 Mindi Dr. Manchester, Nd. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lineboro Cem. Inc. Nov. 28,2005 Lineboro, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Eckhardt Funeral 3296 Charmil Dr. 21. Signature of Funeral Service Licensee Chapel P.A. Manchester, Md. 21102 Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 WKS Immediate Cause (Final disease or condition resulting in death) KESPIRATORY ardine FAILURE **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner of Chronic Disease burial-transit the attending physician hed for use as the burial Rheumstown arthrestes Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 tNo
9 ☐ Unknown Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, , COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy In sufficiency 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 27. Manner of Death Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accider 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident s after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifier Medical within 2 29b. Signature and title of pertifier 0 son who completed cause of death (Ilem 3a) (Type, Print) House Ave DI, FREDCRICK, M. 801 32. Registrar's Signature State Registrar MOU 2 9 2005

| | | | 1 - Stata Registationed Item #5 1. Decedent's Name (First, Middle, Last | | aryland / Dep | | | | _ | gien Reg. N | | 3 8 | 330 | Ļ |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|------------------------------------|------------------------------------|------------------|---------------------------|-------------------------|--------------------------|---------------------------|---------------------------|--------|
| | Physici | an | | , | | O) On | | | Date of De Month | D | ay Ye | | Time of De | ath |
| | /Medic | af | Robert Laws Wate | | | T | | | Novemb | | 27, 200 | | :15A | M |
| | Examin | er | 4a. Facility Name (If not institution, give | | Intra | | m, or Location (| ol Death | | | c. County of D | | | |
| No. | Funeral | 7 | Montgomery Hospic 5. Social Security Number 6. Se | | o (In yrs. last birthday | Rockvi | ear II Under | 24 Hrs. 8 | Date of Bir (Month, Da | | Montgor 9. | | (State or F | oreian |
| | Director | | 577 - 10-3 868 | ДМ 2□F | 83 Yrs. | Months Da | ays Hours | Min. | Oc t. 1 | ау, Үөа . 7 , | 1922 Wa | Country) 1 shin | gton, | DC |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | | | | nside City L | |
| | Mary# | JO. | Maryland Montgomer | *** | Chevy Cha | | | | | | | | XXYes 2 | |
| | death with the Maryland me 23a or 28a-f ehow Entast be mulfilled at | rect | 10e. Street and Number | . у | chevy on | 10f. Zip Cod | de | | | 10g. C | Citizen of What | Country? | | |
| | th with | alD | 9002 Clifford Ave | enue | | 20815 | 5 | | | Uni | ted Sta | ates | | |
| | r dea | Funeral Director | 11. Marital Status | 12. Was Decedent Armed Forces? | | Was Decedent If Yes, specify (| ol Hispanic Ori Cuban, Mexicar | igin? (Speci | fy Yes or No | o- | 14. Race - A Black, W | merican la | ndian, | |
| 9 | be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or lieme 23a or 28a-f ehow event, the Mudical Exempliar must be multiled at | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 XiYes 2 ☐ I II Yes, Give Year or Dates: | № 1942 - 1949 | 1 □ Yes 2🖔 | | | | | Specify: _ | | | |
| 2-003e | 2 hours | | 15. Decedent's Edu | ıcation | 16a. Dece | dent's Usual Oc | ccupation | | | 16b. | Kind of Busine | Vhite | | |
| 0 | within 72 iene. than "n | Completed | (Specify only highest grad Elementary/Secondary (0-12) | le completed) College (1-4or 5 | (Give | kind of work do DO NOT use re | one <i>during</i> mos atired) | t of working | | | | | , | |
| V | filed wit Hygiene other tha | Con | 12 | | | nistrati | ive Off | icer | | U. | S. Gove | rnme | nt | |
| yland | ild be fill lentat Hy ked oth ic event | Be | 17. Father's Name (First, Middle, Last) | | | | | | | | an Sumame) | | | |
| _ | should nd Men marke umatic | 2 | William Henry Wat | | 105 14-11 | Add (Ot | | | a Wool | | | | | |
| <u> </u> | id 2 si ith an 27 ie r traur | | Carol B. Waters/Wi | | | ng Address (Str | | | | - | | | | 15 |
| ā, | permit. Pages 1 and 2 should b Department of Health and Menti Important: if Item 27 is marked eny injury or other traumatic e once. | | 20a. Method of Disposition | | 20b. Place of Disp | osition (Name o | | Novemb | | | Location - City | | | |
| Ē | Page: | | 1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | | Montgome Cremator | matory or other ry | ' - | Novemb 29, 20 | | Re | ethesda | Mai | cv1 and | 4 |
| аппо | permit. Departm Importa eny inju | | 21. Signature o Eugeral Service Licens | | oremator 2 | 2. Name and Ac | dress of Facilit | yRobei | ct_A. | Pum | phrey I | uner | al Ho | me/ |
| מ | 80 5 5 8 | | 1 Caril E 1 | duy. | м00803 | 2. Name and Acethesda- ethesda- | -Cnevy (Maryl: | onase, and | 20814- | 350 | 5/ Wisc 1 | onsi | n Ave | nue |
| | | | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or | ications that caused ne cause on each li | the death. Do not en | ter the mode of | dying, such as | cardiac or r | espiratory a | rrest, | | App | oroximate orval Betwee | en |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. Metasta | atic Malig | nancy of | Unknov | wn Pri | imary | | | On | set and Dea | ,tn |
| | /Medical Examiner | | (Costilling in docum) | Due to (or as | a consequence of): | | | | | | | | | |
| ı | X | er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury | b. Due to (or as | a consequence oi): | | | | | | | | | |
| | d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | • | | | | | | | | | | |
| Ś | ate be executed hysician and the burial-transit | Exe | resulting in death) Last | Due to (or as | a consequence of): | | - | | | | | | | |
| Q/Q | ate by hysic the bu | Ilcal | | d | | | | | | | | | | |
| P X | w requires that the death certificate been signed by the attending phys should be detached for use as the | Physician/Med | IF FEMALE: | 23c. If yes, outcome | of prognancy | | | | | | | | | |
| ğ | death o | clan | in the past 12 months? | | 2 Fetal death 3 | ☐Ectopic pregna ☐ Other (specify | | | | | 23d. Date of Month | delivery Day | Yea | r |
| j. | the d by the | ysle | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | 31 | _ Other (apecity | ·// | | | | | | | |
| , Č | requires that the een signed by th hould be detache | by PI | Part II. Other significant conditions con | ntributing to death b | ut not resulting in the u | inderlying cause | given in Part I. | | 23e. Did t | obacco | use contribute | to the ca | use of deat | h? |
| ecoras, | en sig | | | | | | | | 10 | Yes 2 | 2 □ No 3 □ | Probably | 4∭Unki | nown |
| S | G & C1 | Completed | | | | | | | 24a. Was | | 24b. Were | autopsy f | indings ava | ilable |
| <u> </u> | Thate page | Соп | | | | | | | perfo | rmed? 2X N | death | ? | | 0 01 |
| VII | Physician: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | | | Check only o | | | | | |
| 0 | Phys this ral di | - To | 1 ☐ Yes 2 No | 1 ☐ Inpatie | | IL SU DOA | | | | | 6 Other (S | pecify) [| lospic | e |
| | Attending Firdeath. sctor: After by the funer | ertification: | 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | y Year) Injury | | njury at Work? 1 □ Yes 2 □ I | | a. Describe i | now mji | ury occurred | | | |
| DIVISION | r Attender death | ifica | 3 Suicide 6 Could not be determined | 28e. Place of Inj | ury - At home, farm, st | | | 289 | | | and Number or | Rural Rou | ite Number | |
| ב | Diffe | Cert | 4 Homicide | building, etc | с. (Ѕреспу) | | | | City or Tov | wn, Sta | te) | | | |
| | Hospital 24 hours Funeral letely filled | edlcai | (Check only 2 Medical Exami | sician: To the best | of my knowledge, dea f examination and/or in | h occurred at th | e time, date an | id place, and | d due to the | cause(| s) and manner | as stated. | nauso(s) | |
| | the the | Med | one) 29b. Signature and title of certifies | and manner sta | ated. | | | | | | | | | |
| | 5 1 × 1 × 2 | | 250. Signature allicanie, of certifies | 2// | ill | 7 - | ense number | 10- | | 290. D | ate signed (Mo | onth, Day, | rear) | |
| 7 (| GH > | | 30. Name and address of person who co | ompleted cause of d | eath (Item 23a) (Type | |)412 | 18 | | | 12+1 | 05 | | |
| | /// | | Charles Harriso | | 6001 Munca | | ill Road | d, Roc | kvil1 | e, l | Marylar | nd 2 | 0855 | |
| 1 | Sta | | 21 Data filed (Month Day Veed) | 20 Design | ada Cianatura | | | | | | | | | |
| | Registr | 200 | MOV 2 9 200! |) Blown | . St. Ages | W) | | | | | | | | |
| DH | MH 17 Rev 1/2 | 201 | | | 4 | | | | | | | | | |

| | | • | For State Registrar | State of Maryl | and / Depa | | Health and M | lental Hyg | - | 38305 |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------|-------------------------------------------------|---------------------------------------------------------|
| | | 5 | 1. Decedent's Name (First, Middle, L | ast) | | | | 2. Date of Dea | th _ | 3. Time of Death |
| | Physicia /Medic | _ | | Conrad B. | Wyve11 | | | Novembe | r 24, 2005 | 1:00 PM |
| | Examin | - | 4a. Facility Name (If not institution, g | ve street and number) | | 4b. City, Town, o | or Location of Death | | 4c. County of Dea | th |
| | | \$9 | Montgomery Hospi | ce Casey Hous | e | Rockvi | ille | | Montgome | ry |
| l _e | Funeral Director | | 350 03 3707 | Sex 7. Age (In) | vrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day July 3] | 9. Bir C Wash | thplace (State or Foreign buntry) Lington, D.C. |
| | and * | } | Usual Residence of Decedent 10a. State 10b. County | 10c | City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | 8e-f sho | ector | Maryland Montgo | | Rockvi | 11e | | | | 1 X Yes 2 □ No |
| | with the | 급 | 10e. Street and Number | 4001 | | 10f. Zip Code | 0.50 | | 0g. Citizen of What Co | • |
| | a 23 | 20 | 199 Rollins Aver | | -11.6 | | 852 | | United Sta | |
| 36 | permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified a once. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent Ever i Armed Forces? W 1 X Yes 2 □ No If Yes, Give Year or Dates: | | was Decedent of the Yes, specify Cub | Hispanic Origin? (Sp an, Mexican, Puerto Specify: | ecity Yes or No- Rican, etc.) | 14. Race - Ame Black, White Specify: | |
| 15-00 | in 72 hound "nature | Completed by | 15. Decedent's I (Specify only highest g | Education rade completed) | 16a. Dece (Give life. | dent's Usual Occup kind of work done DO NOT use retire | pation during most of work d) | ing | 16b. Kind of Business | /Industry |
| 212 | d with | E | Elementary/Secondary (0-12) | College (1-4or 5+) | Rea1 | tor | | | Real Esta | te |
| Baltimore, Maryland 21215-0036 | uld be file fental Hyg rked oths tic event, | To Be C | 17. Father's Name (First, Middle, Las Manton Wyvell | • | | | 18. Mother's Name | e (First, Middle, A | • | |
| ary | shou and N | | 19a. Informant's Name/Relationship | (Type, Print) | 19b. Maili | ng Address (Street | and Number or Run | al Route Number | , City or Town, State, a | Zip Code) |
| Σ | alth a | | John M. Wyvell/S | on | 6610 | Mountain | dale Road | , Thurmo | nt, Maryla | nd 21788 |
| ore | of He of He roth | | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 | 20 | b. Place of Dispo | osition (Name of matory or other pla | ce) Nove | Date | 20c. Location - City or | Town, State |
| Ħ | nit. Pag artment ortant: i Injury o | | 4 Donation 5 Other (Spec | ity) M | | | n, Inc. 26, 2 | 2005 | Bethesda, | |
| Ba | Depa impo any ir | | Mugelette Ba | mold Mola | /5 | 3/ Wiscons | in Avenue, I | sethesda, | Maryland 208 | y Chase, Inc. 14-3501 |
| • | Physician /Medical Examiner | Examiner | 23a. Part1. Enter the disease, or coshock, or heart failure. List online disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | y one cause on each line. a. Pneumoni Due to (or as a con Chronic Due to (or as a con | ia sequence of): Aspirat | | ng, 3401 43 64 6420 | or respiratory and | 931, | Approximate Interval Between Onset and Death |
| n. h. 68760, | ysicia e bu | cal | resulting in death) Last | Due to (or as a con | sequence of): | | 7 | | | |
| DEL 17. | To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown | etal death 3 | Ectopic pregnance Other (specify) | у | | 23d. Date of del Month | ivery Day Year |
| / rds, P | quires that n signed t uld be det | d by P | Part II. Other significant conditions Chronic Non-Spe | | | nderlying cause giv | ven in Part I. | | pacco use contribute to | o the cause of death? |
| 00 | w rec | lete | | | | | | 24a. Wasa | n 24h Were au | itonsy findings available |
| al Re | Physicien: The law requires r this certificate has been sign ral director, page 2 should be | Comp | | | | | | autops perform 1 Tes | 2 No 1 □ Yes | itopsy findings available completion of cause of 2 □ No |
| Ξ | Sicia | Be c | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | | O# | 26. Place of Death | | | 110000 |
| on of | ding Phys. Atter this | lon: To | 27. Manner of Death 1 ØNatural 5 ☐ Pending | 28a. Date of Injury (Month, Day Yea | 2 ER/Outpatier 28b. Time o | f 28c. Injui | ry at rk? | me 5 Reside 28d. Describe ho | ow injury occurred | city) HOST LL |
| 0% Division of Vital Records | ai or Attending s after death. ii Director: After id in by the fune | Certification: | 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine | be co- Diagonal Indiana | At home, farm, streetly) | | Yes 2 □ No | 28f. Location (St City or Town | reet and Number or Ru n, State) | ural Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | Medical (| 29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa | Physician: To the best of my aminer: On the basis of examand manner stated. | knowledge, deat nination and/or in | h occurred at the til vestigation, in my o | me, date and place, opinion, death occurr | and due to the cared at the time, d | ause(s) and manner as ate and place, and due | stated. to the cause(s) |
| | To 1 Com | Σ | 29b. Signature and title of certifier | 721/ |) | 29c. Licens | se number | 2 | 9d. Date signed (Mont | h, Day, Year) |
| | | | 1 Call | XIC | | 10 | 44218 | | 11/25/0 | 75 |
| 7 | 2 | | 30. Name and address of person who Charles Harrison | | | | Road, Rock | kville, | Maryland 2 | 0855 |
| 50 | Sta | | 31. Date filed (Month, Day, Year) | 3. Registrar's S | ignature / | | | | - | |
| y . | Registra | ar | NOV 2 9 20 | 105 Filmman | 11 400 | | | | | |

| | | | 1 - For State Registrar | State of Marylan | | ent of Health and ate of Death | Mental Hy | giene 05 | 38306 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------|-----------------------------------|-------------------------------------------------------|--------------------------------------------------------|
| * | Physici | | 1. Decedent's Name (First, Middle, Last | Wiggins | ` | | 2. Date of De Month | Day Yea | |
| 4 | /Medic Examin | | 4a. Facility Name (If not institution, give, | street and number) | 4b. C | lty, Town, or Location of Dea | th | 4c. County of D | 3 7.0 |
| | Funeral | | 5. Social Security Number 6. Se | 7. Age (In yrs. | iast birthday) If Un Yrs. Monti | der 1 Year If Under 24 Hr. | | rth 9. E | Birthplace (State or Foreign Country) |
| | Director | | Usual Residence of Decedent | 7 38 | | | NOV-2 | 3,1917 1 | laryland |
| | a Maryla a-f ehov | ctor | Masyland 10b. County | Toc. Cir | y, Town or Location | ore | | | 10d. Inside City Limits 1 XYes 2 □ No |
| | 3a or 28 | i Director | 10e. Street and Number 4519 Manon | -View R | | Zip Code 21229 | | 10g. Citizen of What | Country? |
| | iteme 2 | Funerai | 11. Marital Status 1 Never Married 2 Marned | 12. Was Decedent Ever in U. Armed Forces? | .S. 13. Was De | cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue | Specify Yes or Norto Rican, etc.) | 0- 14. Race - A Black, W | merican Indian, hite, etc. |
| 0036 | hours after death with the Maryland turel', or Iteme 23a or 28a-f ehow of Exercities from the notified at | þ | 3 Widowed 4 □ Divorced | t ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: | | No Specify: | | Specify: | Black |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "netural", or iteme 23e or 28e-fehow other traumatic event, the Modical Exercities frost the notified at | Completed | 15. Decedent's Edu (Specify only highest grad Elementary (Secondary (0-12) | cation e completed) College (1-4or 5+) | 16a. Decedent's U (Give kind of life DO NO | work done during most of wa | orking | 16b. Kind of Busine | ss/Industry |
| | be filed v tal Hygie d other ti avent, III | Be Co | 17. Father's Name (First, Middle, Last) | | Las | 18. Mother's Na | ime (First, Middle | , Maiden Sumame) | of Mai |
| Maryland | 2 should be and Mental is marked c | To | 19a, Informant's Name/Relationship (T) | (pe, Print) (11ece | 19b. Mailing Addr | ess (Street and Number or F | lural Route Numb | Matthe | WS a, Zip Code) |
| | 1 and 2 Health a em 27 is | | Ms. Margarett | a Kellam | 6602 | Eberle I | rive#3 | 302 Bar | to. Md. 21219 |
| Baltimore, | Page ent o nt: if ry or | | 1 🕅 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | Removal from State | emetery, crematory of | me (1/2 | 19/2005 | Dundo | ilk. Md. |
| Bali | permit. Pag Depertment Important: any injury once. | | 21. Signature of Funeral Service Licens | L. RUM | 22. Name JOSEP 2772 | and Address of Facility | Funer | al Home | P.A. |
| 1 8 | | | 23a. Part / Enter the disease, or compleshock or heart failure. List only of Immediate Cause (Final | | | | | | Approximate Interval Between Onset and Death |
| A de | Physician /Medical Examiner | | disease or condition resulting in death) | Due to (or as adonseq | uence of): | derone Va | culas | alsease. | |
| 4 | p # | Iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury | b. Due to (or as a conseq | uence of): | | | | |
| o, | icate be executed physicien and s the burial-transit | Examiner | that initiated events resulting in death) Last | Due to (or as a conseq | uence of): | | | | |
| 68760, | lificate be execut g physicien and as the burial-tran | edical | · · | d | | | | | |
| Вох | ath cer | Physician/M | in the past 12 months? | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d | death 3 Ectopic | pregnancy | | 23d. Date of o | delivery Day Year |
| P.O. | 0 0 | Physic | 1 Yes 2 No 9 Unknown | 9□ Unknown | | | | | |
| ords, | sign sign d be | ed by | Part II. Other significant conditions co | ntributing to death but not res | uiting in the underlyin | g cause given in Part I. | | | to the cause of death? Probably 4 Unknown |
| of Vital Record | e law hes b | Completed | | | | | 24a. Was auto pend | an 24b. Were psy prior to death | autopsy findings available o completion of cause of |
| Vital | Physicien: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | 1 Tes | 2 X No 1 □ Y | es 2. No |
| n of | Phys this al dii | on: To | 1 ☐ Yes 2 M No | 28a. Date of Injury (Month, Day Year) | ER/Outpatient 3 28b. Time of Injury | DOA Other: 4 Nursing 28c. Injury at Work? | | dence 6 □Other (S _i how injury occurred | oecify) |
| Division | or Attending efter death. Director: After In by the funer | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At he | | 1 ☐ Yes 2 ☐ No | 28f. Location (| Street and Number or | Rural Route Number, |
| Ö | To the Hospital or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the | | | building, etc. (Specify sician: To the best of my kno | | ed at the time, date and place | City or To | | as stated |
| | To the Ho within 24 h To the Ful completely | Medical | (Check only one) 2 Medical Exemi | ner: On the basis of examina and manner stated. | tion and/or investigati | on, in my opinion, death occ | urred at the time, | date and place, and d | ue to the cause(s) |
| | Z1 | | 1 Snoth | Bergun | MO | | 19 1 | 29d. Date signed (Mo | |
| r | | | 30. Name and address of person who | 1 ^ | Hackhoore | 900 Caho 1 | WOOGA | Balhove | Maryland |
| STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY | Sta Registi | | 31. Date filed (Month, Day Vear) NOV 2. 9. 26 | 32. Agistrar's Signa | iture | | 779 | | mo you |

| | | | For Stata Ragistrar | State of | Maryland / Dep <i>Ce</i> | artment of F rtificate of | | | giene Reg. No. 0 0 5 | 38307 | |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------|---------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|--|
| | División: | | 1. Decedent's Name (First, Middle, Las | t) | | | | 2. Date of Dea | Day Voos | | |
| | Physici /Medic | | Matthew Wright | | | | | Novemb | er 16 200 | 05 11:30PM | |
| | Examin | er | 4a. Facility Name (If not institution, give 127 Faywood Ct. | | per) | 4b. City, Town, o | Burnie | | 4c. County of De | Arundel | |
| | Funeral Director | | -10 00 0101 | ex 7 | Age (In yrs. last birthday) 62 Yrs. | If Under 1 Year Months Days | If Under 24 H | Irs. 8. Date of Birt In. (Month, Day June 4 | n y, Year) 9. Bi 1943 Ma | rthplace (State or Foreign Country) Lryland | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. fnside City Limits | |
| | Mary 4 • hc | Ď | Maryland Anne A | rundel | Glen | Burnie | | | | 1 ☐ Yes 2 💢 No | |
| | r 28a | Irec | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What C | country? | |
| | th with | a D | 127 Faywood Ct | . Apt E | 3 | 210 | 60 | | USA | | |
| 36 | ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Heelth and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f ehow or other traumatic event, the Mydical Examinar must be notified. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced | 12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat | ΜNο | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ②CMo | lispanic Origin? an, Mexican, Pu Specify: | (Specify Yes or No- uerto Rican, etc.) | 14. Race - Am Black, Wh Specify: B | ite, etc. | |
| 21215-0036 | 2 hou | ted | 15. Decedent's Ed | lucation | 16a. Dece | dent's Usual Occup | pation | | 16b. Kind of Busines | s/Industry | |
| 215 | hin 7. | Completed | (Specify only highest gra | de completed) College (1-4 | life. | kind of work done DO NOT use retired | during most of d) | working | Anne Aru | ndel Co. | |
| | ed wil | Con | 9th | 0 | | stodian | | | | Education | |
| Maryland | be till d oth | Be | 17. Father's Name (First, Middle, Last) Alfonzo Wright | | | | | Name <i>(First, Middle,</i> Godbolt | Maiden Sumame) | | |
| 2 | hould d Mer marke marke | ဥ | 19a. Informant's Name/Relationship | | 10h Maili | an Address (Ctons | | | - C+ - T C+ - | 7.044 | |
| Ma | d 2 sl th an t7 is r | | Mary Wright (Mo | | | E. 31s | | | or, City or Town, State, Ore, Md. | | |
| ē, | Heel Heel | | 20a. Method of Disposition | , | 20b. Place of Dispo | osition (Name of | | Date | 20c. Location - City o | | |
| <u>و</u> | Peges ent of nt: if i | | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | relogie proper | %Val¦ 11 | -23-05 | Annapoli | s. Md. | |
| Baltimore, | permit. Peges 1 and 2 should be tiled within Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then any injury or other traumatic event, Item Magnee. | | 21. Signature of Funeral Service Licen | | MON 457 2 | 2. Name and Addre | ss of Eacility e & So St. A | ns Mortu | arv, P.A | | |
| | | | 23a. Part1. Enter the disease, or com- shock, or heart failure. List only | plications that cau | used the death. Do not en | | | | | Approximate Interval Between | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. A C | ute Mys c as a consequence of): | andia! | difia | ction | | Onset and Death | |
| | Examiner | | Sequentially list conditions, | n G | ronagy (| etery | Dise | earl | | | |
| . / | ס == | Iner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o | as a consequence of): | | | | | | |
| V | sicien and burial-transit | Examiner | that initiated events resulting in death) Last | C | as a consequence of): | | | | | | |
| 8760, | cate be ex ohysicien the burial | al E | | D00 10 (0) | as a consequence or). | | | | | | |
| 687 | licate phys s the | edical | | d | | | | | | | |
| Box (| leath certitic ettending p I tor use as | Physician/Me | fF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 1□Live birt | | ∃Ectopic pregnancy | / | | 23d. Date of de | elivery Day Year | |
| P.O. I | thet the death cerred by the ettending detached for use | hysic | 1 Yes 2 No 9 Unknown | 4☐Pregnar 9☐Unknov | nt at time of death 5[/n | Other (specify) _ | | | IVIOLITI | Day real | |
| Vital Records, P | es De | þ | Part II. Other significant conditions of | ontributing to dea | th but not resulting in the u | inderlying cause giv | ren in Part I. | 23e. Did to | bacco use contribute | to the cause of death? | |
| 00 | sw requir s been si s should | Completed | Ala | alul A | huse | | | 24a. Was | an 24b. Were a | utopsy findings available completion of cause of | |
| æ | The fav | E | | 1 | ., | | | autop perfor 1 Yes | sy prior to med? death? 2☐No 1☐Ye | | |
| ital | ien: artitice ctor, p | Be C | 25. Was case referred to medicat examiner? | | | | 26. Place of I | Death (Check only o | | 3 20 140 | |
| of < | Physicien: this certition ral director, | ၉ | 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ fng | | | 4 | g Home 5 ☐ Resid | ence 6 Other (Sp. | ecify) | |
| , <u>C</u> | ing P | ion: | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | | Injury 28b. Time of Injury | Wor | | 28d. Describe h | low injury occurred | | |
| Division | death death ctor: / | cat | 2 Accident investigation 3 Suicide 6 Could not be | | f Injury - At home, farm, st | | Yes 2 No | 28t Logation (6 | Stragt and Mushau as F | | |
| Ď | al or A after i Direct d in by | Certification: | 4 Homicide determined | building | n, etc. (Specify) | теет, тастогу, опісе | | City or Tow | itreet and Number or F m, State) | tural Houle Number, | |
| | To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Medical C | 29a. Certifier | ysician: To the b niner: On the bas and manne | est of my knowledge, deal is of examination and/or in r stated. | th occurred at the tire | ne, date and planting pinion, death o | ace, and due to the occurred at the time, o | cause(s) and manner a date and place, and du | s stated. e to the cause(s) | |
| | To th withir To th comp | Me | 29b. Signature and title of certifier | / / A . | | 29c. Licens | e number | | 29d. Date signed (Mgr | th, Day, Year) | |
| | | | 1 45 | MA | MD | | 504 | 10 | 11/22/0 | 5 | |
| | 3 | | 30. Name and address of person who SRIDHAR. A'TIUI | completed cause | of death (Item 23a) (Type | Print) Hoo | 4, | araden | a MD | 21122 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 9 2 | 32. 5 | gistrar's Signature | Card | V | | | | |

State of Maryland / Department of Health and Mental Hygie ${ extbf{7}}005$ 38308 Figure 1. The second state of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HAROLD LAUCKS XANDERS November 24, 2005 5:56am M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1926 9. Birthplace (State Months Days Hours Min. JULY 5, 2005 MARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**½** M 2□ F 79 Director 219-28-0117 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 27 is marked other then "netural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director MDBALTIMORE 1 ☐ Yes 2 ☐ XHo OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 GARRISON FOREST 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2 🌠 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STOCK BROKER STOCK BROKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi ISRAEL LAUCKS XANDERS HENRIETTA PARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,1\,1\,7$ permit. Pages 1 end 2 Department of Health a Important: If Item 27 is eny injury or other trat once. SUSAN XANDERS 104 GARRISON FOREST RD. OWINGS MILLS MD. wife 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) THOMAS CHURCH 11/29/2005 OWINGS MILLS, MD. 22. Name and Address of Facility HENRY W. JENKINS 16924 YORK RD MONKTON, MD. 21111 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acidemia /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Be Completed by Physician/Medical IF FEMALE: USe. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō 4 Pregnant at time of death Dav Year 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has autopsy perform 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpafient 2 ER/Outpatient 3 DOA Certification: To E S 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 🗀 Accident Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Mghth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1er 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

| | | | 1 - State Amend Item 1 Registrar | State of Mary 10b-c per fh | land / Dep G 49 Le | artment of -29-05 to | Health and | d Mental Hyg | giene 005 | 38309 |
|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------|-------------------------------|-------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, La | | 19 | | | 2. Date of Dea | | 3. Time of Death 5:45 P M |
| | Examir | | 4a. Facility Name (If not institution, give Future Care | (4) | gton | 4b. City, Town | n, or Location of De | | 4c. County of Dea | |
| | Funeral Director | | | | yrs. last birthday 9 Yrs. |) If Under 1 Ye Months Da | | Hrs. 8. Date of Birth lin. (Month, Day OCT • 14 | v, Year) | nthplace (State or Foreign ountry) OUI, Korea |
| | ne Maryland 8a-f ehow outlied et | Director | 10a. State 10b. County Maryland Baltimo | re Gity | c. City, Town or L - Waverly | | nore | | | 10d. Inside City Limits XXXYes 2 □ No |
| | eth with the 23a or 2 | rai Dire | 11 W. 20th Stree | · | | 10f. Zip Cod 21 | e 218 | | 10g. Citizen of What C United Sta | , |
| 900 | be filed within 72 hours efter deeth with the Maryland that Hygiene. In deet then "natural", or fleme 23a or 28a-f ehow event, the Medical Examinar must be notified at | d by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2700 If Yes, Give Year or Dates: | r in U.S. 13. | Was Decedent of If Yes, specify C | uban, Mexican, Pu | (Specify Yes or No- uerto Rican, etc.) | 14. Race - Am Black, Whi | te, etc. |
| Baltimore, Maryland 21215-0036 | e filed within 72 h at Hygiene. I other then "natu vent, the Medical | Completed | 15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) | ducation ade completed) College (1-4or 5+) | (Give | edent's Usual Oc e kind of work do DO NOT use rei Mal | ne during most of ired) | working | 16b. Kind of Business Garments | s/Industry |
| yland; | | To Be C | 17. Father's Name (First, Middle, Last Chang H. Yang | | | | 18. Mother's 8 Bok S | Name (First, Middle, | Maiden Sumame) | |
| e, Mar | 7 £ N 2 | | 19a. Informant's Name/Relationship (Mr. Charles Yan 20a. Method of Disposition | g (Son) | 18417 | Ensor I | Farm Coun | | or, City or Town, State, Maryland 20c. Location - City or | 21120 |
| altimo | it. Pe ritmen ritant: njury | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Lice | Removal from State | Dulaney | Valley | Mem. 11/ | /25/ 2005 | Timonium, | MD. |
| e E | permi Depe Impo any li gno | | 23a. Part1. Enter the disea of company of company of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o | Polications that caused the | 12 | 325 York | Rd. Time | onium Ma | ryland 21 | Approximate |
| | Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a co | osele | rotie | | | ar disease | Interval Between Onset and Death |
| oʻ | cate be executed by siclen and the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a co | | | | | | |
| 68760, | | edical | | d | | | | | | |
| .O. Box | that the death certific led by the attending p detached for use as | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 | □Ectopic pregna □ Other (specify) | | | 23d. Date of de Month | livery Day Year |
| ٥. | The law requires that are has been signed by page 2 should be deta | ρ | Part II. Other significant conditions of | contributing to death but no | ot resulting in the u | underlying cause | given in Part I. | | bacco use contribute t | o the cause of death? |
| al Records, | | Completed | | | | | | 24a. Was a autop: perfor 1 \(\text{ Yes} \) | sy prior to | utopsy findings available completion of cause of |
| f Vital | Ø .∞ .च | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient | 2 ☐ ER/Outpatie | nt 3 DOA | 24 | Death (Check only or | ence 6 □Other (Spe | icify) |
| Division of | Attending Ph r death, ector: After th by the funeral | Certification; | 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be | | ar) 28b. Time o | V | njury at Vork? Yes 2 No | | ow injury occurred | |
| Divi | To the Hospitel or Attending I within 24 hours efter death. To the Funerel Director: After completely filled in by the funer | | 4 Homicide determined | building, etc. (S | pecify) | | | City or Tow | | |
| | To the Hospitel or within 24 hours efte fo the Funerel Direction places of the formpletely filled in h | Medical | (Check only 2 Medical Example one) 29b. Signature and title of certifier | nysician: To the best of my miner: On the basis of exa and manner stated. | mination and/or in | evestigation, in m | y opinion, death or | ccurred at the time, d | late and place, and du | e to the cause(s) |
| | +3±8 | _ | Amatun A 30. Name and address of person who | 1 Macen | //tom (25) (Tr | \mathcal{I} | 155 | 03/ | Jov 25 | 3 2005 |
| 'l | 1 | | 31. Date filed (Month, Pay, Year) | 32. Begistrar's S | m 501 | Doll | PHIM S | T, BA | LTUMD | 21917 |
| | Sta Registi | | or, cate med (worth, bay, real) | oc. Pagipirars | aignakure La | 1.0. | | | | |

| | | 1 - For State Registrar | State of Maryland | Department of F | | | CUUS | 38310 |
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| 9 9 8 | Ž _O | Decedent's Name (First, Middle, La | ast) | - Cortinoato or | Doutri | 2. Date of Deat | eg. No. | 3. Time of Death |
| Physici | | RETTY Locally | = 7FIIER | | | Novemb | er 26 200 | ar 3 |
| /Medic | | 4a. Facility Name (If not institution, given | ve street and number) | 4b. City, Town, o | or Location of Death | NOVC: 10 | 4c. County of D | |
| | À., | | gton Modical Ce | nter Gler | Burni | e | Anne | Arundel |
| Funeral Director | | | Sex 7. Age (In yrs. last | birthday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Month, Day, | _7 \ 12 | Birthplace (State or Foreign Country) ENNS-LVANIA |
| yland wow | | 10a. State 10b. County | 10c. City, T | own or Location | | | | 10d. Inside City Limits |
| deeth with the Maryland rms 23e or 28s-f show rmat be notified at | ctor | MD ANNEA | RUNDET GL | EN BURN | JIE | | | 1 ☐ Yes 2 TVNo |
| or 28 | Oire | 10e. Street and Number | - 1 | 10f. Zip Code | | 1 | 0g. Citizen of What | Country? |
| s 23a | ral | 102 N. CRAIN I | | 210 | 261 | | U.S. | A· |
| ter de | Funeral Director | 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No | 13. Was Decedent of H If Yes, specify Cuba | lispanic Origin? (Spe an, Mexican, Puerto I | ecify Yes or No- Rican, etc.) | | merican Indian, /hite, etc. |
| Zeller, Battimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show way injury or other treumatic event, the Madical Exacination at the notified at page. | by | 3 □ Widowed 4 Proivorced | If Yes, Give Year or Dates: | 1 ☐ Yes 2 No | Specify: | | Specify: | UNITE |
| 5-0 72 ho | Completed by | 15. Decedent's E (Specify only highest gr | ducation 1- | 6a. Decedent's Usual Occup (Give kind of work done | pation during most of worki | na | 16b. Kind of Busine | ss/Industry |
| within lene. | mpi | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NOT use retired | | | £1 =0 =0 | 0> |
| Hyge de Hitter | ပိ | 17. Father's Name (First, Middle, Last | | roduction (| 18. Mother's Name | | ELECTH | RONICS |
| Mental affice. | To Be | 1-LOYD D'RI | DARK | | | Journ | maiden Sumame) | |
| 2 shou and M | - | 19a. Informant's Name/Relationship | | 9b. Mailing Address (Street | | | City or Town, State | e, Zip Code) |
| ore, Miss 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 and 2 is 1 | | SANDRAREED) | DAUGHTER E | 5011 | 0 1 - | LORE, N | | 25 |
| nord Heart Read And Andread | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | | e of Disposition (Name of etery, crematory or other place | , D | ate | 20c. Location - City | or Town, State |
| Zelle) Baltimore, permit. Peges 1 and Department of Healt Important: If them 2 and injury or other and eace. | | 4 ☐ Donation 5 ☐ Other (Speci | (V) SAY | IIEW CREMA | TORY 11-3 | 10-05 E | SALTIMOR | E, MD. |
| Balti permit. Depertin Imports any inju | | 21. Signature of Funeral Sovice Lice | hund | 2601 | amily Funeral Ho | Pacadona M | ID 21122 | , |
| | | 23a. Part1. Enter the disease, or seri shock, or heart failure. List only | nplications that caused the death. D | o not enter the mode of dyin | ig, such as cardiac o | r respiratory arre | est, | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition resulting in death) | _a | gestive hear | of failure | | | Onset and Death |
| /Medical Examiner | | resulting in dealin) | Due to (or as a consequent | ce of): | | | | |
| ************************************** | er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. — Due to (or as a consequence | ce of): | | | | |
| outed ransit | Examiner | that initiated events | C | | | | | |
| 68760, Refere to executed physicien and sthe burial-transit | | resulting in death) Last | Due to (or as a consequence | ce of): | | | | |
| 8760, cate be ex physicien the burial | dicai | • | d | | | | | |
| X 6 Sertific | /Me | IF FEMALE: | 23c. If yes, outcome of pregnancy | | | | | |
| Bo leath death atten | cian | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 2 Fetal dea 4 Pregnant at time of death | ath 3 Ectopic pregnancy | | | 23d. Date of Month | delivery Day Year |
| ds, P.O. Box 6 iries that the death certif signed by the attending d be detached for use as | Physician/Me | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 9☐ Unknown | | | | | |
| S, D | by P | Part II. Other significant conditions | | g in the underlying cause give | en in Part I. | 23e. Did tob | acco use contribute | to the cause of death? |
| cords w require been sig | pet | chrone obstructive | - pulmonay diseas | e | | 1 X Ye | s 2 🗆 No 3 🗆 | Probably 4 □Unknown |
| ecc lawri | Completed | coronorp artes | & groots | | | 24a. Was ar autopsy | | autopsy findings available o completion of cause of |
| The The cete h | Con | | | | | perform | red? death | es 2 No |
| Vita ician: certific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | l ou | 26. Place of Death | | | |
| Of Phys | . To | 1 Yes 25 No 27. Manner of Death | | Outpatient 3 DOA Other | + intersing non | | nce 6 Other (S | ресity) |
| Division of Vital Records, P.O. Box for Attending Physician: The law requires that the death cer effer death. After this cartificate has been signed by the attendir in by the funeral director, page 2 should be detached for use | Certification: | 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio | (Month, Day Year) | Injury Worl | k? Yes 2 □ No | od. Describe no | w injury occurred | |
| ivis | rtific | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At home, building, etc. (Specify) | farm, street, factory, office | 2 | 8f. Location (Str City or Town | eet and Number or State) | Rural Route Number, |
| Dital of urs of orel Differed in | | 00 0 00 | | | | | , | |
| Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours elfer death. To the Funciel Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical | 29a. Certifier (Check only one) 2 Medical Example 1 Medical Example 2 Medical Example 1 Medical Example 2 Medical Example 1 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Example 2 Medical Ex | hysician: To the best of my knowled miner: On the basis of examination and manner stated. | ige, death occurred at the tin and/or investigation, in my op | ne, date and place, a pinion, death occurre | nd due to the ca d at the time, da | use(s) and manner ite and place, and d | as stated. ue to the cause(s) |
| To tl withi To tl | Σ | 29b. Signature and fittle of certifier | y/h | 29c. License | e number | | d. Date signed (Mo | |
| | | +11 | MONMO | | 18719 | N | ovember 2 | 6,2005 |
| \ | | 30. Name and address of person who | no 201 Hospit | 1 D M | a Cucai- | | | |
| Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | PICOC U DA | HONING! | | | |
| Registr | | NOV 2 9 | 2005 Mayer 15 | Sporte | | | | |
| DHMH 17 Rev 1/20 | 001 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Volkman 24 4b. City, Town, or Location of Death 4c. County of Death PARKVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 03/12/1916 1 ☐ M 2 🖫 F 89 MARYLAND 10b. County 10c. City, Town or Location BALTIMORE PARKVILLE 10f. Zip Code 10g. Citizen of What Country? 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc.

Physician FERN R. ZIMMERMAN /Medical 4a. Facility Name (If not institution, give street and number) Examiner OAK CREST VILLAGE CARE CENTER 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 212-16-2601 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD 10e. Street and Number 8832 WALTHER BLVD. items 23a Completed by Funeral 72 hours after ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12ÝRS US. GOVERNMENT CLERICAL CLERK 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be is 1 and 2 should be fi of Health and Mental F itam 27 is marked of WILLIAM MOLLER HELEN MERTZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (BRO.-IN LAW) 2906 MONKTON RD MONKTON, MD 21111. LYAL PEYTON JR. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ital
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State MONKTON MRTHODIST 11/28/2005 MONKTON, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO
16924 YORK RD MONKTON, MD. SONS CO. 21. Signature of Fungral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to introductions. Enter Underlying Cause (Disease or injury Dua to for as a nonsequence off resulting in death) Last Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown o 9 Unknown 23e. Did tobacco use continute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 Mo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 25. Was case referred medical examiner? 26. Place Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manney of Death 28b. Time of Certification: or Attending 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2005

IN ME PIMAS

5-0036

2121

32. Agistrar's Signature

| | | | 1 = For State Registrar | State of Maryla | | artment of F rtificate of | | | giene 0 0 5 | 38312 |
|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|---------------------------------------------------|----------------------------------------------------|
| * | Physicia /Medic | | 1. Decedent's Name (First, Middle, Las Phyllis | | Axarlis | 5 | | 2. Date of Dea Month Novembe | Day Year | 3. Time of Death 8:46 PM |
| 100 | Examin | | 4a. Facility Name (If not institution, give Holy Cross Hospit 5. Social Security Number 6. S | al | s. last birthday) | 4b. City, Town, o Silver If Under 1 Year | r Location of Death Spring If Under 24 Hrs. | 8. Date of Birth | 4c. County of Dea | |
| New York | Funeral Director | | | D | 54 Yrs. | Months Days | Hours Min. | 1/26/1 | (951) Gr | ountry) eece |
| | Maryland -f ehow | tor | 10a. State 10b. County Maryland Montgome | | City, Town or Lo neaton | ecation | | | | 10d. Inside City Limits 1 Yes 2 No |
| | ath with the Marylan 23a or 28e-f ehow | al Director | 10e. Street and Number 12918 Valleywood | Drive | | 10f. Zip Code 2090 | 6 | | 10g. Citizen of What C USA | country? |
| 36 | s after deat , or items ; | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in Amed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: | | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No | lispanic Origin? (S an, Mexican, Puert Specify: | pecify Yes or No- pecify Yes or No- pecify Yes | 2 4 | |
| 21215-0036 | be filed within 72 hours after death with the Maryland stal Hygiene. do other than "naturel", or items 23a or 28e-f show event, I're Medical Exartinal; and the inclified at | Completed b | 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) | ducation | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most of wor d) | king | 16b. Kind of Busines | s/Industry |
| 1d 21 | Hygi other | Be Con | 12 17. Father's Name (First, Middle, Last) | | Unde | rwriting | 18. Mother's Nan | | Insurance Maiden Surname) | : |
| Maryland | 12 should be filed withic n and Mental Hygiene. Fis marked other than raumatic event, ILE Mi | Tol | Thomas La 19a. Informant's Name/Relationship (Konstantinos Axar | * - | | | | ral Route Numbe | Konidas r, City or Town, State, in MD 20906 | |
| altimore, I | permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked eny injury or other traumatic engines. | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific | 20b. | Place of Dispo cometery, crea | esition (Name of matory or other place Heaven Ce | em. 11/ | Date 10/2005 | 20c. Location - City of Silver Sp | r Town, State |
| Balti | permit. Departn imports eny inju | | 21. Signature of Funeral Service Licer | Red | | | | | ldi Funera Silver Spr | 1 Home ing MD 20904 |
| 68760, | Physician pe executed attending physician and attending physician and for use as the burial-transit | edical Examiner | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | plications that caused the de- one cause on each line. a. Renal Cand Due to (or as a conse Due to (or as a conse C. Due to (or as a conse Due to (or as a conse d. | cer equence of): er equence of): | er the mode of dylr | g, such as cardiac | or respiratory an | rest, | Approximate Interval Between Onset and Death |
| P.O. Box 6 | The law requires that the death certifiate has been signed by the attending page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown | 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown | ital death 3 | □Ectopic pregnancy □ Other (specify) _ | / | | 23d. Date of d Month | elivery Day Year |
| | quires that I in signed by uld be deta | þ | Part II. Other significant conditions of | contributing to death but not re | esulting in the u | nderlying cause gw | en in Part I. | , | obacco use contribute 'es 2 □ No 3 □ I | to the cause of death? Probably 4 2 Unknown |
| il Records, | The law requir | Completed | | | | | | 24a. Was autop perfor 1 Yes | sy prior to | |
| of Vital | Physician: r this certific ral director, |) Be | 25. Was case referred to medical examiner? | Hospital: | ☐ ER/Outpatie | Ott | or. | th (Check only o | | |
| Division of | Afte Afte | Certification: To | 1 Yes 2 TNo 27. Manner of Death TNO Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be | 28a. Date of Injury (Month, Day Year) | 28b. Time o | f 28c. Inju | 4 🗀 Nursing 🗅 | 28d. Describe h | dence 6 Other (Sp low injury occurred | |
| DİXİ | <u>2</u> | | 3 Surcide 6 Could not be determined | 28e. Place of Injury - At building, etc. (Spec | | reet, factory, office | | 28f. Location (S City or Tow | Street and Number or I vn, State) | Rural Route Number, |
| | To the Hospital or Attan within 24 hours after death virtue 25 that Eunaral Director: completely filled in by the | Medicai | (Check only 2 Medical Examone) | nysician: To the best of my k miner: On the basis of exam- and manner stated. | | vestigation, in my o | ppinion, death occu | rred at the time, | date and place, and di | ue to the cause(s) |
|) | S with | 2 | 29b. Signature and title of certifier | WURL | | | 3850 | | 29d. Date signed (Moi | |
| | | | 30. Name and address of person who Steven Schwartz M | 1.D. 1500 F | orest (| len Road | ; Silver | Spring 1 | MD | |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 1 4 | 32 legistrar's Sig | nature A | arkis | | | | |

| | | | 1- State of Maryland / Department of State of Maryland / Department of Certificate | of Death | Reg. f | - | 38313 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------|-----------------------------|----------------------------------------------------|
| | Physici | | 1. Decedent's Name (First, Middle, Last) DOROTHY P. ARTAUD | 1 | 2. Date of Death Month November | 200 ⁵ 5° | 3. Time of Death 7:30 PM |
| | /Medic Examir | | 4a. Facility Name (If not institution, give street and number) 4b. City, Tov Suburban Hospital Bethe | wn, or Location of Death | | c. County of Dea | ıth |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y | | 8. Date of Birth Nov. 24,19 | | thplace (State or Foreign |
| | Director | | Usual Residence of Decedent | | NOV. 24,19. | ZI Cal | ifornia |
| | Marylan I show | lor | MD Montgomery 10c. City, Town or Location Bethesda | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | vith the | Director | 10e. Street and Number 10f. Zip Co 5716 Ogden Road 208 | | | Citizen of What C | ountry? |
| | death v | Funeral I | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 15. Was Decedent If Yes specify | t of Hispanic Origin? (Spec Cuban, Mexican, Puerto R | cify Yes or No- | 14. Race - Am Black, Whi | |
| 920 | urs after el', or Ite | <u>و</u> ا | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 Yes Year or Dates: | | noarr, oto., | Specify: Wh | |
| 15-0 | n 72 ho • netur | Completed | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work of life, DO NOT use of | Occupation done during most of working retired) | g 16b. | Kind of Business | /Industry |
| 212 | ed withi ygiene. ner than it, the M | Comp | 5+ Concert Pia | nist/Instruc | ctor | Music | |
| land | should be filled within 72 hours after death with the Maryland not Mental Hygiene. s marked other than *neturel', or Items 23a or 28e-1 show umatic event, the Mcdical Examinar must be notified at | To Be | 17. Father's Name (First, Middle, Last) Henry J. Profant | 18. Mother's Name (| (First, Middle, Maide G. Spetzma | | |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23s or 28e-1 show amy injury or other traumatic event, the Medical Examiner must be notified at ODGs. | | 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (St. Marie-Catherine Artaud-Lara 3404 Turner | treet and Number or Rural | | | Zip Code) |
| ore, | es 1 an of Heal f item 2 r other | | 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State | of Da | | Location - City or | Town, State |
| Baltimore, | artment ortent: Pag injury of | / | `4 □Donation 5 □Other (Specify) Mt. Comfort Crem | natory Nov.9, | | | |
| ä | Dep Imp | | Million R. Dugge 5130 Wis | sconsin Ave. | N.W., WDO | | |
| 8 | Pnysician | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failule. List only one cause of each line. Immediate Cause (Final disease or condition | nzmir hat | | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) a. Due to (or as a consequence of): | Ter (III) | | | 3 a dys |
| | p # | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | |
| , | cate be executed physician and the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | |
| 8760, | cate be physicia the bur | dical | d | | | | |
| Box 6 | leath certific attending p | an/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy | nancy | | 23d. Date of de | |
| o. | that the dea led by the at detached fo | Physician/M | 1 Yes No 9 Unknown 5 Other (specification of death 5 Other (specification) | у) | | Month | Day Year |
| rds, P. | w requires that been signed t should be det | by | Part II. Other significant conditions contributing to death but not resulting in the underlying cause | e given in Part I. | | ~/ | o the cause of death? |
| Records, | e la has | Completed | | | 24a. Was an autopsy performed? | prior to death? | utopsy findings available completion of cause of |
| Viital | | o Be C | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 ppatient 2 ER/Outpatient 3 DOA | 26. Place of Death / | (Check only one) | | |
| n of | Attending Physicien: ar death. ector: After this certification in the funeral director. | - | 27. Manner of D + th 28a. Ate of Injury 28b. Time of Injury Injury 28c. Injury 28c. Injury 28c. Injury 28c. | Injury at 28 Work? | e 5 Residence 3d. Describe how inj | | city) |
| Division of | Attender death | Certification: | 4 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify) | 1 Yes 2 No | Bf. Location (Street a City or Town, Sta | und Number or Ri | ural Route Number, |
| ā | • Hospital or Attend 24 hours after death • Funeral Director: etely filled in by the t | | 29a. Certifying Physicien: To the best of my knowledge, death occurred at the | he time, date and place, an | | , | stated |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical | (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in and manner stated. | my opinion, death occurred | d at the time, date a | nd place, and due | to the cause(s) |
| | Twit To To | | 296. Signature and Alley of Certifier | 2347 | 290. 0 | ate signed (Mont | way, rear) |
| | 15 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | nd Center | D-, 1 | ckville | MD |
| | Sta Registi | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | |

| _ | For | |
|----|-----------|--|
| 1_ | State | |
| - | Registrar | |

| | | = State Registrar | | Ce | rtificate of I | Jeath | | Reg. No. | 100 | 30317 | | | |
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| Dhucis | » ده | 1. Decedent's Name (First, Middle, | , Last) | | | | 2. Date of De. Month | Death 3. Time of Death | | | | | |
| Physic /Medi | | BETTY JEAN MOORE AUSTIN Nov. 4, 20 | | | | | | | | 7:46 P | | | |
|) Exami | ner | 4a. Facility Name (If not institution, Civista Medica | 1 Center | | LaPlata, | | 4c. County of Death Charles | | | | | | |
| Funeral Director | | 5. Social Security Number 275–32–4567 Usual Residence of Decedent | 6. Sex 7. Age (| 9 Yrs. | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bird (Month, Da APRIL 2 | y, Year) 25,19 | 36 OH | irthplace (State or Foreig Country) IIO | | | |
| land ow | | 10a. State 10b. County | 1 | 0c. City, Town or L | ocation | | | 10d. Inside City Limits | | | | | |
| ith the Marylar or 28a-f show | ctor | MARYLAND CHARLE | S | WALDORF | | | | | | 1 Tyes 2 X N | | | |
| ith the | Dire | 10e. Street and Number | | | 10f. Zip Code | _ | | | en of What C | | | | |
| death with the Maryland ims 23s or 28a-f show | la | 4785 YOUNG ROAD | 140 W 5 | | 2060 | | | | ED STA | ATES nerican Indian, | | | |
| 5 2 3 | Funeral Director | 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ev Armed Forces? ed 1 Yes 2 No If Yes, Give | ei iii 0.5. 15. | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo | | Rican, etc.) | | Black, Wh | nite, etc. | | | |
| 5-0036 72 hours after 'natural', or it | d by | 3 Widowed 4 Divorced | Year or Dates: | | | | | | Е | BLACK | | | |
| 15-0 | Completed | 15. Decedent (Specify only highes | t grade completed) | life. | edent's Usual Occup e kind of work done DO NOT use retired | ation during most of work f) | ing | 16b. Kin | d of Busines | s/Industry | | | |
| 712 iene. | E O | 12TH GRADE | College (1-4or 5+) | SAL | ES CLERK | | | | RETAIL | 1 | | | |
| al Hyg | BeC | 17. Father's Name (First, Middle, L | Last) | | | 18. Mother's Name | e (First, Middle, | Maiden S | umame) | | | | |
| Vlat Duid b Menta arked | 70 | AARON MOORE | | | | | | | | | | | |
| Maryland d 2 should be file th and Mental H 27 Is marked oth traumatic even | | 19a. Informant's Name/Relationsh | | and Number or Rur | | • | | | | | | | |
| e, l 1 and Health em 27 ther t | | CARMEN W. WILSON 20a. Method of Disposition | N / DAUGHIER | 20b. Place of Disp | Osition (Name of | | Date PIAR | | | or Town, State | | | |
| nor ages ant of t: If it | | 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | I | ematory`or other place MEMORIAL GA | | 12 2005 | | , | | | | |
| Baltimore, permit. Pages 1 a Department of Her mportant: If item any injury or othe 2015. | | 21. Simulature of Funeral Service | 0 | | | | | | | A., INDIAN HEAI | | | |
| Depa impo | | LYDÍA C. THORNT | ON JOHNSON MOO | | R FISHER FU | | | | - | | | | |
| G.M. | | 23a. Part1. Enter the disease, or shock, or heart failure. List (| complications that caused the | ne death. Do not er | nter the mode of dyir | g, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between | | | |
| Physician | | Immediate Cause (Final disease or condition | REST | 1RATOR | FAIL | | | | | Onset and Death | | | |
| /Medical | | resulting in death) | Due to (or as a | consequence of): | | | | | | | | | |
| Examiner | L | Sequentially list conditions, | b | consequence of): | PATITY | | | | | | | | |
| ted sit | nine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | consequence on. | } | | | | | | | | |
| axecu | Examiner | that initiated events resulting in death) Last C. Due to (or as a consequence of): d. | | | | | | | | | | | |
| 68760, tilicate be exe g physicien a as the burial- | cal | | | | | | | | | | | | |
| | /Medical | IF FEMALE: | | | | | | | | | | | |
| | | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 Live birth 2 | , | | 23 | 3d. Date of d Month | elivery Day Year | | | | | |
| O. E. | Physiciar | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4☐ Pregnant at tii 9☐ Unknown | me of death 5 | Other (specify) | | | - | | | | | |
| Is, P.O. Bo | Ph | Part II. Other significant condition | ns contributing to death but | not resulting in the | underlying cause giv | en in Part I. | 23e. Did t | obacco us | e contribute | to the cause of death? | | | |
| rds, | d by | | | | | | 1 🗆 ' | Yes 2□ | No 3 | Probably 4 Unkno | | | |
| s been si | Completed | | | | | | 24a. Was | | 24b. Were | autopsy findings availal | | | |
| Re ta | E O | | | | autor perfo | ormed? 2 \Box | death? | o completion of cause of es 2 2 No | | | | | |
| 'ital | BeC | 25. Was case referred to medical examiner? | | | | 26. Place of Deat | | | | | | | |
| S ce dire | 2 | 1 ☐ Yes 2 No | | 2 ER/Outpatie | | 4 Nuising no | | | | pecify) | | | |
| 6 5 7 | - :: | 27. Manner of Death 1 X Natural 5 Pending | | Year) 28b. Time Injury | Wor | yat k? Yes 2 □No | 28d. Describe | now injury | occurred | | | | |
| on of ing Phy After thi | 0 | | ation] | | | | | | | | | | |
| ision of the death. ctor: After this funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the | lication | 3 Suicide 6 Could r | not be 200 Bloom of Injur | v - At home, farm, s | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State) | | | | | | | | |
| Division of Vital Records, P.O. Bc at or Attending Physicien: The law requires that the death after death. I Director: Alter this certificate has been signed by the attendin by the funeral director, page 2 should be detached for the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th | ertification | 3 Suicide 6 Could r | not be 28e. Place of Injur | | treet, factory, office | | | | | | | | |
| Division of enospital or Attending Phy 24 hours after death. • Funeral Director: After thisely filled in by the funeral | dical Certification: | 3 Suicide 6 Could r determ 4 Homicide 129a. Certifier 12 Certifyin | not be 28e. Place of Injur | (Specify) my knowledge, dea examination and/or i | ith occurred at the tir | ne, date and place, pinion, death occur | City or Ton | wn, State) cause(s) a | and manner a | as stated. ue to the cause(s) | | | |
| Division of Vital Rec To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical Certification | 3 Suicide 6 Could r determ 3 Suicide 1 Could r determ 29a. Certifier 1 Certifyin (Check only 2 Medical I | 28e. Place of Injurbuilding, etc. g Physician: To the best of Examiner: On the basis of e | (Specify) my knowledge, dea examination and/or i | ath occurred at the fir nvestigation, in my c | pinion, death occur e number | City or Ton | cause(s) a | place, and di | as stated. ue to the cause(s) nth, Day, Year) | | | |
| Division of To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | | 3 Suicide 4 Homicide 29a. Certifier (Check only one) (Check only one) | 28e. Place of Injurbuilding, etc. g Physician: To the best of Examiner: On the basis of e | (Specify) my knowledge, dea examination and/or i | ath occurred at the till nvestigation, in my c | pinion, death occur e number | City or Ton | cause(s) a | place, and di | ue to the cause(s) | | | |
| To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of | | 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title at sentifier 30. Name and address of person Morindont Smith | 28e. Place of Injurbuilding, etc. g Physician: To the best of Examiner: On the basis of e and manner state who completed cause of dea | my knowledge, deaxamination and/or isd. | 29c. Licens | pinion, death occur e number 25 | City or Toil | cause(s) a date and p | signed (Mon | nth, Day, Year) | | | |
| To the Hospital or within 24 hours after To the Funeral Directions completely filled in 1 | | 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title in sertifier | 28e. Place of Injurbuilding, etc. g Physician: To the best of Examiner: On the basis of e and manner state who completed cause of dea | my knowledge, deaxamination and/or isd. | 29c. Licens | pinion, death occur e number 25 | City or Toil | cause(s) a date and p | signed (Mon | nth, Day, Year) | | | |

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| ## Microlland Second Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control | | | | 1. Decedent's Name (First, Middle, La | ast) | Certificate of Death | 2. Date of Death | 3. Time of Death |
| Financial Director Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Comparison Compariso | | | | EISIE C | BLAND | | NOVEMB | W 11 2005 8:30 AM |
| Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number | | Examin | er | 011 1/11 51 | 1 | Par | ath C 1.L. | 1 |
| Compared to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con | | | | 5. Social Security Number 6. | Sex 7. Age (In yrs. last b. | irthday) If Under 1 Year If Under 24 Hr | s. 8. Date of Birth (Month, Day, Ye | O Dietrologo (Chara en Consisso |
| Elementary Secondary Color College (1-4of 5+) | | | | 211-14-3621 | 83 | Yrs. | 3-18-3 | nd, |
| Elementary Secondary Color College (1-4of 5+) | | aryland show | _ | 10a. State 10b. County | / | | | 10d. Inside City Limits |
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| Elementary Secondary Color College (1-4of 5+) | 10 | ter de l'instru | Fune | | Armed Forces? | 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | |
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| | isio | Attendi death. ctor: A y the fu | ficat | 2 Accident investigation 3 Suicide 6 Could not l | De Blood of Injury At home 6 | | 28f. Location (Street | and Number or Rural Route Number |
| So se de de de de de de de de de de de de de | Div | Hospital or Atteno 24 hours after deatl Funaral Diractor: tely filled in by the | Certi | 4 Homicide | building, etc. (Specify) | | City or Town, Sta | ate) |
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| the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co | | To the within To the comple | Me | | • 1 | 29c. License number | 29d. [| Date signed (Month, Day, Year) |
| Mary 2 Ille ma D24871 11/14/05 | | | | Mary L | Illy mo | D24871 | 11 | 114/05 |
| H. 3 30. Name and address of legeon to completed a se of death(Item 23a) (Type, Print) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) | H | . 3 | | 30. Name and address of erson of 30. | MOST MAIN | ance mp 2 | 1851 | · |
| State 31. Date filed (Month, Day, Year) NOV 1 5 2005 32. Adjistrar's Signature | | | | 31. Date filed (Month, Day, Year) | 2005 32. Adjistrar's Signature | Specie | | |

| | | | For State Registrar | State of Ma | ryland | | | | lealth a | | _ | gien Regin | 11111 | 38316 |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------|-----------------------|---------------------------------|--------------------------|---------------------|-----------------|---------------------------------------|-----------------------|------------------------------------------------|-----------------------------------------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, I Mary Juani | · | | | | | | | 2. Date of De Month | D | ay Year | 3. Time of Death |
| | /Medi Examir | | 4a. Facility Name (If not institution, g | | | | 4b. City | , Town, or | Location (| of Death | 11/02 | | c. County of Dea | 2:20 p M |
| | | | Doctor's Hosp | ital | | | | | ham | | | | P.G. | • |
| | Funeral Director | 1250,0 | 213-40-7449 | 5. Sex 7. Age 1 ☐ M 25€ F | (In yrs. Ia | st birthday) Yrs. | If Unde Months | | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da April | v Yea | ^{9. Bir} 1940Man | thplace (State or Foreign ountry) Cyland |
| | land land | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | Mary a-f sh | tor | MD Prince | Georges | | Spri | ngd | ale | | | | | | 1 XYes 2 □ No |
| | th the | Jired | 10e. Street and Number | | | | | p Code | | | | - | itizen of What Co | ountry? |
| | ath w | ral | 9020 Taylor | | | | | 2077 | | 0 /0- | N | | .S.A. | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event. In Medical Evanting must be notified at SARE. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent E Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: | | | was Deci f Yes, sp 1 Yes | ecify Cuba | Specify: | n, Puerto | ecify Yes or No Rican, etc.) |)- | 14. Race - Ame Black, White Specify: B 1 | te, etc. |
| 9 | 2 hou | ted | 15. Decedent's | Education | | 16a. Dece | dent's Us | ual Occup | ation | | | 16b. | Kind of Business | /Industry |
| 21215-0036 | d within 7 giene. ir then "n | Completed | (Specify only highest (Secondary (0-12) 1 2 | College (1-4or 5+ | -) | Bus | DO NOT | use retired | during mos t) | it or worki | ng | Go- | verment | : |
| land | uld be fifed Aental Hygid rked other tic event, I | To Be C | 17. Father's Name (First, Middle, La Joseph Owen B | | | | | | | | e E. B | | , | |
| lary | 2 should and Men is marke eumatic | | 19a. Informant's Name/Relationship | | | | • | | | | | | or Town, State, | |
| Baltimore, Maryland | es 1 and of Health fitem 27 r other tr | | Ear1 L. Beard/ 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 | | | 9020 ace of Dispo | 4 | | | | ngdale | | D 20774 Location - City or | |
| Ĕ | Pages ment of lant: If it | | 4 □Donation 5 □ Other (Spe | ecify) | Ft. | Linco | | | | | | | entwood | |
| Ball | permit. Departr imports any inj | | 21. Signature of Funeral Service Lic | censee | | | | | | | - | | uneral hingtor | |
| | Physician | | 23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition | omplications that caused the caused line one cause on each line of SUBARACF | э. | | | | ig, such as | cardiac o | or respiratory a | rrest, | | Approximate Interval Between Onset and Death Hours |
| | /Medical Examiner | | resulting in death) | Due to (or as a | consequ | ience of): | | | IRE | | | | | Hours |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a | consequ | ience of): | | | | | | | | Hours |
| 8760, | death certificate be executed e attending physicien and d for use as the burial-transit | | resulting in death) Last | Due to (or as a | consequ | ience of): | | | S | | | | | Years |
| 9 | rtificat ng phy as th | Aedi | IF FEMALE: | | | | | | | | | | | |
| O. Box | ne death certific the attending pl thed for use as i | Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t | 2 🗌 Fetal | death 3[| Ectopic Other (s | pregnancy pecify) | ′ | | | | 23d. Date of de Month | livery Day Year |
| ۵. | requires that the deserving the hould be detached | by | Part II. Other significant condition | s contributing to death bu | t not resu | Ilting in the u | nderlying | cause giv | en in Part I | l. | | | | o the cause of death? |
| Vital Records, | e taw has t | Completed | | | | | | | | | | psy ormed? | prior to death? | utopsy findings available completion of cause of |
| tal | ician: Th certificate rector, pag | 0 | 25. Was case referred to medical | | | | | | 26. Place | e of Deatl | 1 ☐ Yes | 2€ □ N one) | lo 1 ☐ Yes | s 2 No |
| | Physician: this certitic ral director, | To B | examiner? 1 ☐ Yes 2 🎇 No | Hospital: | nt 2 🗆 I | ER/Outpatier | nt 3 🗆 🗆 | Oth | 0.0 | | | | 6 □Other (Spe | ecify) |
| ion of | ding h. After fune | | 27. Manner of Death 1 XNatural 5 Pending 2 Accident investiga | | Year) | 28b. Time o Injury | f M | 28c. Injur Wor 1 [| yat k? Yes 2□ | | 28d. Describe | how in | ury occurred | |
| Division | or At Olrect in by | Certification: | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | | ry - At ho . <i>(Specify</i> | me, farm, st | reet, facto | ry, office | | | 28f. Location (City or To | | | lural Route Number, |
| | To the Hospital or All Swithin 24 hours after or Yo the Funeral Direct completely filled in by | edical | | Physician: To the best o xaminer: On the basis of and manner stat | examinat | | | | | | | | | |
| | To the Symithic Comp | Ž | 29b. Signature and title of certifier | 1 | | | 2 | | e number | | | | ate signed (Mon | |
| | SK | | 1/ | | - | | | Ċ | 13906 |) I | | 1 | 1/07/20 | JU5 |
| | 15 | | | no completed cause of de | | | | т. | | | 125 - | | - WD (| 0077/ |
| | Si | ate | George H. Bon 31. Date filed (Month, Day, Year) | 32. Registra | r's Signal | cant: | ılе | Lane | sui | LT # | 135 La | arg | o, MD 2 | 20//4 |
| W Z | Regist | | NOV 1, 4 2005 | Elever X | 400 | de | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** 22:35 John William Brittingham, Jr. /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Wicomico Peninsula Regional Medical Center Salisbury Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9/29/194 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** X M 2□F Months Days Hours 64 MD 214-36-5962 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examt act must be cutified at once. 10c. City, Town or Location 10d Inside City Limits 10a State 10h Counts 1 Tyes 2 K No Director Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 304 Locust Terrace Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Vides 2 1 No 1959 - 64

Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Health Care 3 Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Cropper John W. Brittingham, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10120 Waterview Dr., Ocean City, Md. 21842 Patricia Lynn Cropper 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 11-11-2005 Frankford, DE ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease or complications shock, or heart failure. List only one caus Approximate Interval Between Onset and Death Immediate Cause (Final Anteriosclerotic Heart Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tes 2X No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation 1 X Natural after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 THomicide 24 hours a Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Ver 054807 11-10-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 East Carroll St., Salisbury, Md. 21801 Ramesh Agarwal, M.D. 31. Date filed (Month, Day, Year) 32. Signature State NOV 1 4 2005 Registrar

| | | | For State | State of Maryland / | | rtment of H | | • | giene | 5 38318 | |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------|------------------------------------------------------------------|---------------------------------------|------------------------------------------|-------------------------|------------------------------------------------------------------|---|
| | | | Registrar 1. Decedent's Name (First, Middle, Las | t) | | inouto or a | | 2. Date of Dea | | 3, Time of Death | |
| | Physici | an | MARGARET JACQUE | | | | | Month | Day | Year | |
| | /Medic | | 4a. Facility Name (If not institution, give | | | 4b. City, Town, or | Location of Dea | <u>Novembe</u> | er 6 20 4c. County o | 005 10:24 A ^M | |
| | Examin | er. | 8701 Allentown R | | | Fort Was | | | | | |
| | Funeral | | 5. Social Security Number 6. Se | | irthday) | If Under 1 Year_ | If Under 24 Hi | s. 8. Date of Birt | | 9. Birthplace (State or Foreign Country) |) |
| | Director | | 233-36-4848 | □M 253F 77 | Yrs. | Months Days | Hours Mi | n. (Month, Da | | Tamroy, WV | |
| | D. | | Usual Residence of Decedent | | | | · · · · · · · · · · · · · · · · · · · | 10001 | | | _ |
| | nylan ihow | _ | 10a. State 10b. County | 10c. City, To | wn or Lo | cation | | | | 10d. Inside City Limits | |
| | e Ma | cto | Maryland Prince Ge | eorge's Coll | ege | Park | | | | 1 X Yes 2 □ No | |
| | ih th or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of Wh | hat Country? | |
| | be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, the Medical Evanical must be notified at | | 7300 Radcliffe Dr | ive | | 20740 | | | U.S.A. | | |
| | r dez | Funeral | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. V | Vas Decedent of Hi Yes, specify Cuba | spanic Origin? n, Mexican, Pue | (Specify Yes or No- orto Rican, etc.) | - 14. Race Black | - American Indian, | |
| 36 | or it | by Fu | 1 Never Married 2 Married | 1 ☐ Yes 2 🔀 No If Yes, Give | 1 | ☐ Yes 2☑ No | Specify: | | Specify: | White | |
| 21215-0036 | ural | | 3 XWidowed 4 □ Divorced | Year or Dates: | - 0 | | | | | WILLE | _ |
| 7 | "nat | Completed | 15. Decedent's Ed (Specify only highest grad | | (Give | ent's Usual Occupa kind of work done d OO NOT use retired, | furing most of w | orking | 16b. Kind of Bus | iness/industry | |
| 12 | withir ane. than | E G | Elementary/Secondary (0-12) | College (1-4or 5+) | _ | · | | | Rakin | g Goods | |
| 7 | filed Hygie othar | | 12th 17. Father's Name (First, Middle, Last) | | EH | treprenei | | ame (First, Middle, | | | _ |
| Baltimore, Maryland | 2 should be filed and Mental Hygi is markad othar aumatic evant, I | Be | | | | | Ruth | | Griffit | 1_ | |
| Ž | es 1 and 2 should be i of Health and Mental i f itam 27 is markad o Sother traumatic eve | ဥ | Emery Lamaster 19a. Informant's Name/Relationship (7 | Type Print) 19 | h Mailin | a Address (Street a | | Augusta Rural Route Numbe | | | |
| Ma | d 2 s th an 7 is 1 | 1 | Iolanda Ruth Bune | | | | | | • | MD 20744 | |
| e, | 1 and Healt Bm 2 thar | | 20a, Method of Disposition | 20b. Place | of Dispo | sition (Name of | | Date | | City or Town, State | - |
| ٥ | it of | | 1 Burial 2 Cremation 3 | Removal from State cemet | ery, cren | natory or other place | - 1 | 10 10000 | | | |
| ŧΪ | ritmer ritant | | '4 □ Donation 5 ☒ Other (Specify | | | | | | | d, Maryland | |
| Bal | permit. Pages 1 Department of H. Important: If ital any injury gott | | 21. Signature of Funeral Service Licen | 5 +· | HĨ | NES-RINA | LDI FUN | ERAL HOME | I, INC. | | |
| | 40244 | | Noncy A. | 1se cen Ve | | | | | | oring, MD 20904 | 4 |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | one cause on each line. | o not ente | er the mode of dying | g, such as cardi | ac or respiratory ar | rrest, | Interval Between Onset and Death | |
| E | Physician | | Immediate Cause (Final disease or condition | a Metastatic Can | cer, | Unknown | Primar | 7 | | | |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequence | e of): | | | | | | |
| | Lxummer | | Sequentially list conditions, | b. Severe Cachexi | | com Malig | nancy | | | | |
| | od sit | Examiner | ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence | o off. | | | | | | |
| | and tran- | cam | that initiated events resulting in death) Last | c | 0.06\: | | | | | | _ |
| 8760, | The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit | Ē | | Due to (or as a consequence | e 01). | | | | | | |
| 87 | physic the b | dicai | | d | | | | | | | _ |
| 9 | eath certific attending p | 0 | IF FEMALE: | One If we a subseme of programs | | | | | | | |
| Вох | ath c | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea | | Ectopic pregnancy | | | 23d. Date Mont | of delivery th Day Year | 1 |
| 0. | the der by the a tached f | sic | 1 ☐ Yes 2 🖾 No 9 ☐ Unknown | 4 Pregnant at time of death 9 Unknown | 5∟ | Other (specify) | | | | | |
| Ρ. | that the | Physician/M | Part II. Other significant conditions co | antichuting to doubt but not requiting | in the | adorbina onuco euro | n in Part I | 230 Did to | obacco uso contrit | bute to the cause of death? | _ |
| Ś | ires the signe | þ | | | | | miiraiti. | | | 3 ☐ Probably 4 ⊠Unknown | |
| Records, | w requir been si should | ted | Chilonic Obsti | uctive Airway Di | seas | е | | | 165 2 110 0 | 7 Trockery 4 Zorikirowi | |
| ec | law as be | ple | | | | | | 24a. Was autop | osy pri | fere autopsy findings available for to completion of cause of | n |
| æ | | Completed | | | | | | | | eath? □ Yes 2□ No | |
| Vital | ician: certific rector, | Be (| 25. Was case referred to medical examiner? | | | | 26. Place of D | eath (Check only o | ne) | | |
| \$ | dis dis | 2 | 1 ☐ Yes 2 ☒No | Hospital: 1 ☐ Inpatient 2 ☐ ER/C | Dutpatien | t 3□ DOA Othe | er: 4 Nursing | Home 5 Resid | dence 6 🙀 Other | (Specify) Daughter | 1 |
| n of | | | 27. Manner of Death 1 28Natural 5 ☐ Pending | 28a. Date of Injury 28b (Month, Day Year) | . Time of Injury | 28c. Injury Work | / at c? | 28d. Describe h | now injury occurred | Residence | |
| Division | Attending r death. ector: After by the fune | atic | 2 Accident investigation | | | | Yes 2 □ No | | | | |
| Vis | or Atter de Directe | tific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury · At home, building, etc. (Specify) | farm, str | eet, factory, office | | 28f. Location (5 City or Tox | | r or Rural Route Number, | |
| | Hospital or A | Certification: | | | | | | | | | |
| | lospi hour uner uner | edical | | ysicien: To the best of my knowled niner: On the basis of examination a | | | | | | | |
| | in 24 the F | edi | one) | and manner stated. | | | | | | | |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in L | Σ | 29b. Signature and title of certifier | 0 | | 29c. License | | | | (Month, Day, Year) | |
| • | | | Chalale | - Berzingi | MI |) D0056 | 986 | | November | r 8, 2005 | |
| | Le | | 30. Name and address of person who | completed cause of death (Item 23a | | | | | | | |
| _ | | | Chalak Berzingi, | | | | ite #10 | 5, Green | belt, Mar | ryland 20770 | |
| | Sta | ate | 31. Date filed (Month, Day, Year) | 32 Registrar's Signature | Sen | ends 3 | | | | | |
| | Regist | rar | NOV IU Z | UUD THE EURO AT | Jag Ch | | | | | | |

| | | | 1 - For State Registrar | State of N | /laryland | | artmen rtificate | | | | | giene () Reg. No. | 5 3 | 18319 |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------|-----------------------------------------------|---------------------------------|-------------------------------|-----------------------------------|--------------------------|----------------------------|--------------------------|---------------------------------------|-------------------------------|-----------------------------|--------------------------------------------------|
| | Dhamini | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of Dea | ath Day | Year | 3. Time of Death |
| | Physici: /Medic | | MABEL | D. | BROY | LES | | | | | Novembe | | 2005 | 2:05 PM ^M |
| | Examin | | 4a. Facility Name (If not institution, | give street and numbe | r) | | 4b. City, | Town, or | Location of | of Death | | 4c. Cou | nty of Death | |
| | | | FRIENDS NURS | ING HOME | | | | | SPRIN | | | | | |
| | Funeral | | | S.Sex 7.7 1 □ M 2 X F | Age (In yrs. li 97 | as <i>t birthday)</i> Yrs. | If Under Months | 1 Year Days | If Under | 24 Hrs. Min. | 8. Date of Birt (Month, Day | Day, Year) Country) | | |
| | Director | | 218-56-2593 | TOM EVAL | 91 | Yrs. | | | | | June 9 | 1908 | Ter | nessee |
| | and * | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | ocation | | | | | | | 10d, Inside City Limits |
| | Aarylan F show | ō | Md. Monto | gomery |] | Brooke | ville | <u> </u> | | | | | | 1 Tes 2 XNo |
| | 28a-1 | ect | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Citizen | of What Cou | ntry? |
| | with | ā | 21814 Georgia A | Avenue | | | TOIL ZIP | 208 | 333 | | | | ed Sta | • |
| | eath | Funeral Director | 11. Marital Status | 12. Was Deceder | nt Ever in U. | S. 13. | Was Decec | | | ain? (Spe | cify Yes or No- | | Race - Ameri | |
| 10 | iter d | Fun | 1 Never Married 2 Marrie | Armed Forces | s? | | | | n, Mexican | , Puerto | cify Yes or No- Rican, etc.) | 8 | Black, White, | etc. |
| 936 | urs a | by | 3 ⊠ Widowed 4 □ Divorced | If Yes, Give Year or Dates | s: | | 1 ☐ Yes | 2 X (No | Specify: | | | Spe | city: V | Mhite |
| 21215-0036 | within 72 hours after death with the Maryland one. than "natural", or Itams 23a or 28a-f show fre Modical Excoller must be notified at | Completed | 15. Decedent's | Education | | 16a. Dece | dent's Usua | al Occupa | ation | t of worki | 20 | 16b. Kind of | Business/Ir | ndustry |
| 21 | thin 7 | pje | Elementary/Secondary (0-12) | College (1-4o | or 5+) | | kind of wor DO NOT us | |) "To mig most | O WOTKI | 19 | 0 | Home | |
| 21 | ad wi | Con | 8 | 0 | | поше | maker | | | | | | | |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiens. Department of Health and Menial Hygiens Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any highest Examine must be notified at any highest of the most of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of the market of th | Be | 17. Father's Name (First, Middle, L. | ast) Reaves | | | | | | illi ϵ | (First, Middle, | | ame) | |
| yla | ould Men arke | 은 | Oscar Monroe | | | | | | | | | | | |
| Jar | 2 sh and Is m | | 19a. Informant's Name/Relationshi Mildred Oland | | | | | | | | Brooker | | | o <i>Cod</i> e) 20833 |
| e) | 1 and 1ealth 1m 27 ther t | | 20a. Method of Disposition | Dadgireer | 20h Pi | lace of Dispo | | | 1 | • | ate | 20c. Locatio | | |
| Baltimore, | Seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguent of the seguen | | 1 ⊠ Burial 2 □ Cremation | | te C6 | emetery, cre | matory or o | ther plac | . | | | | , | |
| ţ | rtant njury | | ' 4 □ Donation 5 □ Other (Special Signature of Funeral Service L | | Bu | rtonsv | LLTE 2. Name an | | | | 12/05 | Burte | onsvii | le, Md. |
| Ba | perm Depa Impo any i | | mwy of | di Bay | her. | | Muri | el E | I. Bar | rber | Funera | | | |
| | | | 23a, Part1. Enter the disease, or o | omplications that caus | ed the death | Do not en | | | | | Laytons | | Md. | 20882 Approximate |
| Ш | | | shock, or heart failure. List o Immediate Cause (Final | nly one cause on each | line. | ii Do Hot OH | | o or ayırı | 9, 00000 | our dido o | . roophatory at | 1001 | | Interval Between Onset and Death |
| | Pnysician /Medical | | disease or condition resulting in death) | DEMEI | | | | | | | | | | 2 Yrs. |
| | Examiner | | | Due to (or a | as a consequ | ience of): | | | | | | | | |
| | | ō | Sequentially list conditions, | b. Due to (or a | as a consequ | ence of | | | | | | | - | |
| | nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | | | | | | | | | | | |
| | al-tra | Exal | that initiated events resulting in death) Last | Due to (or a | as a consequ | ience of): | | | | | | | | |
| 8760, | cate be executed obysician and the burial-transit | | | 4 | | | | | | | | | - | |
| 89 | ificate g phy as the | Physician/Medical | | | | | | | | | | | | |
| Вох | leath certifica attending ph for use as th | Z | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | | 75 | | | | | 23d. | Date of deliv | ery |
| | death e atte d for | icia | in the past 12 months? 1 ☐ Yes 2 ☑No | 1 ☐ Live birth 4 ☐ Pregnant | at time of de | | ⊒Ectopic pr ⊒ Other <i>(sp</i> | | | | | | Month | Day Year |
| 0 | that the de ed by the detached | hys | 9 Unknown | 9□ Unknown | | | | | | | | | | |
| ٦, | The law requires that the death centificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit | by P | Part II. Other significant condition | s contributing to death | but not resu | ulting in the u | nderlying c | ause give | n in Part I. | | 23e. Did to | | | he cause of death? |
| Records, | w require been sig should b | ed | | | | | | | | | 1 🗆 Y | es 2 No | 3 ☐ Prol | bably 4 Unknown |
| 000 | aw requisible been 2 should | plet | | | | | | | | | 24a. Was autop | | b. Were auto | opsy findings available empletion of cause of |
| Ä | The I | Completed | | | | | | | | | perfor | med? 2 No | death? | |
| Vital | siclan: The law s certificate has b lirector, page 2 s | O | 25. Was case referred to medical | | | | | | 26. Place | of Death | (Check only o | - | | |
| V | Physiclan: this certific ral director, | To B | examiner? 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpa | atient 2 🗆 I | ER/Outpatier | nt 3 DC | A Othe | er: 4XNu | rsing Hor | ne 5□Resid | lence 6 🗆 0 | Other (Specia | (y) |
| Jo C | | | 27. Manner of Death 1X Natural 5 ☐ Pending | 28a. Date of Ir (Month, L | njury Day Year) | 28b. Time o | f 2 | 8c. Injury Work | at c? | 2 | 28d. Describe h | ow injury occ | curred | |
| <u>i</u> | Attending r death. actor: Afte by the fune | atic | 2 Accident Investiga | ation | | | М | | Yes 2□I | No | | | | |
| Division | l or Attendater death Diractor: | Certification: | 3 Suicide 6 Could no 4 Homicide determin | 200. Flace UI | Injury - At ho etc. (Specify | me, farm, st | reet, factory | , office | | 1 | 28f. Location (S City or Tow | | mber or Run | al Route Number, |
| | ital or its afte ral Dir led in | | | | | | | | | | | | | |
| | To tha Hospital or Attenwithin 24 hours after deatl To tha Funaral Diractor: completely filled in by the | Medical | (Check only 2 Medical E | Physicien: To the be xeminer: On the basis | of examinat | wledge, deat ion and/or in | h occurred vestigation, | at the tim , in my or | ne, date an pinion, dea | d place, a th occurre | and due to the o ed at the time, o | cause(s) and date and plac | manner as s e, and due t | stated. o the cause(s) |
| | tha tha tha mplet | Med | one) 29b. Signature and title of certifier | and manner | stated. | () | 290 | License | number | | T : | 29d. Date sig | ned (Month | Day Year) |
| | 7 × · · · · · · · · · · · · · · · · · · | | 255. Signature and the property | 22 | -0 | 2 | MAZ | | D-058 | 00 | | | | |
| 7 | 4 | | | | A don't 'i' | 220\ (T | Dries! | | D-038 | 09 | | МОД | emper | 9, 2005 |
| | | | 30. Name and address of person w John G. Lodmel | tho completed cause o | 2905 C | | | 01: | ney, | Md. | 20832 | | | |
| | Sta | ate | 31. Date filed (Month, Day, Year) | | strar's Signat | ture | well | | | | | | | |
| | Regist | | NOV 10 | 2005 | 160 1 | · Partie | A. Carriera | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** NOVEMBER 15. 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 40PKINS THEJOHNS TI Unde 9. Birthplace (State or Foreign Social Security Numbe Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1□M 2√2 49 218-64-8554 Director 3. 1956 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at WV. Mineral Piedmont 1 Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Ashfield 26750 United States St. 81 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 🔀 No Be Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 12 permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mildred Baker Wilt Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 336 Front St., Westernport, Maryland 21562 Tonya Broadwater/ daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/18/ Cross, West Virginia Sinclair Mem. Park 4 □ Donation 5 □ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Tu ayr 111 Church St, Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ORGAN DAYS /Medical Due to (or as a consequence of): Examiner ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed ALUULAR 20 Physician/Medical YEARS IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖾 Inpatient 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D0062091 Cun mo NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEWIS, MD, 600 N. WOIFE St., BALTIMORE, MD 21287 CHRISTO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2005 NOV Registra

| | | Please 1 - For State Registrar | Type or Prin | | Depa | | lealth and M | • | • | e. 5 38321 | | |
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| Physici /Medio Examin | cal | 1. Decedent's Name (First, Middle, Last) Waltraud Bohatsch 4a. Facility Name (If not institution, give street and number) | | | 4b. City, Town, a | r Location of Death | 2. Date of De Month Nov. | | | | | |
| Funeral Director | | FutureCare Chesapeake 5. Social Security Number 215-35-1853 Chesapeake 7. Age (In yrs. last birth product) 89 | | | | If Under 1 Year Months Days | Arnol If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | th 9 | Anne Arundel 9. 8 irrhplace (State or Foreign Country) 1916 Czechoslovakia | | |
| the Maryland 28a-f show | ector | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel 10e. Street and Number 11 | | | Arnold | | | 10g. Citizen of Wha | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No | | | |
| s 1 and 2 should be filed within 72 hours after death with the Maryland 1 and 2 should be filed within 72 hours after death and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Madical Examiner must be multified. | / Funeral Director | 305 College Parks 11. Marital Status 1 Never Married 2 Married | Way 12. Was Decedent I Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give | | | 2 | 21012 ispanic Origin? (Sp In, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | US 0- 14. Race - 8lack, | • | | |
| within 72 hours aftens. 606. than "natural", or | Completed by | 3 XWidowed 4 □ Divorced Year of Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 | | | a. Deced (Give life. I | ient's Usual Occum | ation during most of work | ing | 16b. Kind of 8usiness/Industry Home | | | |
| 2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Mental country. | To Be Co | 17. Father's Name (First, Middle, Last) Edward Hanusch | | | 9b. Mailir | 18. Mother's Name (First, Middle, I Anna Krotsch ling Address (Street and Number or Rural Route Number | | | | · | | |
| permit. Pages 1 and 2 s Department of Health and 2 land 1 mportant: if item 27 lan any injury or other treu <u>once.</u> | | Frank Richardson/Son-in-Law 1311 Argyll Drive, Arnold, MD 21012 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 7, Removal from State | | | | | | y or Town, State | | | | |
| permit. Pa Department Important any folury once. | | 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 | | | | | | | | | | |
| Physician /Medical Examiner | Examiner | 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Z4 hours after death. To the Lansral Director: After this certificate has been signed by the attending physicien completely filled in by the funeral director, pege 2 should be detached for use es the burial | Physician/Medical E | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | of pregnancy | th 3 | Ectopic pregnancy | | | 23d. Date o | | | |
| faw requires that that the bean signed by 2 should be detact | Completed by Phy | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left pleuval effusion, opacified Left Hemithoxox, thistory of subarachnoid 24a. Was an autopsy frior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior to completion of cause of prior | | | | | | | | | | |
| Physician: The law this certificate has b al director, pege 2 s | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Seath | Hospital: 1 Inpatie | | | | 4 Nursing Ho | 1□ Yes h (Check only o | one) dence 6 Other (| Yes 2 No | | |
| To the Hospital or Attending Physician: The I within 24 hours after death. To the Funsral Director: After this certificate he completely filled in by the funeral director, page | Certification: | 27. Manner of Jeath 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred | | | | | | | or Rural Route Number, | | | |
| fo the Hospita vithin 24 hours to the Funeral ompletely filler | Medical C | 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa pumber 29d. Certifier 29d. Date signed (Month, Day, Year) | | | | | | | | | | |
| p∞ ≥ p∞ () | | 30 Name and address of person who | completed cause of d | eath (Item 23a | i) (Type, | Print) Los | 41955 | #204 | 11-Ca | lesville | | |
| Sta Registi | | 31. Date filed (Month, Day, Year) | 32. gish | ar's Signature | / (| Raine | ~ 1179 | nney | y MC | 21108 | | |

| | | | 1- For State of Ragistrar | Marylan | | | of Health and i | | ene 2.005 | 38322 |
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| | | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death Month | | 3. Time of Death |
| | Physici /Medio | | Frances W. Beard | | | | | Nov. | 7, 2005 | 12:30a M |
| | Examir | ner | 4a. Facility Name (If not institution, give street and numi | per) | | 4b. City, Tow | m, or Location of Deatl | 1 | 4c. County of De | ath |
| | | | FutureCare Chesapea | | | | Arnold | | | Arundel |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 M 2 X F Usual Residence of Decedent | . Age (In yrs. I | Yrs. | If Under 1 Y Months Da | ear If Under 24 Hrs. ays Hours Min. | 8. Date of Birth (Month, Day, Jun. 19, | ^{9. B} 1922 | irthplace (State or Foreign Country) FL |
| 215-0036 | land ow | | 10a. State 10b. County | 10c. Cit | y, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Marylan I show | ģ | MD Anne Arundel | | | Arnold | | | | 1 ☐ Yes 2 🔯 No |
| | h the | irec | 10e. Street and Number | | | 10f. Zip Cod | de | 10 | g. Citizen of What (| Country? |
| | 23a c | aiD | 402 Century Vista Drive | | | | 21012 | | USA | |
| | ems ems | To Be Completed by Funeral Director | 11. Marital Status 12. Was Deced | es? | S. 13. \ | Was Decedent | of Hispanic Origin? (S Cuban, Mexican, Puert | pecify Yes or No- | 14. Race - An Black, Wh | |
| | or It | | 1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 | oN □ | | l ☐ Yes 2☑ | | 0 7 110411, 010.7 | Specify: | White |
| | hour turel' | | 3 XWidowed 4 ☐ Divorced Year or Dat 15. Decedent's Education | əs: | | to the time to | | | | |
| | in 72 n" n | | (Specify only highest grade completed) | | (Give | lent's Usual Od kind of work do DO NOT use re | one during most of wor | king | 6b. Kind of Busines | s/Industry |
| 212 | yiene. r then " | | Elementary/Secondary (0-12) College (1-4or 5+) | | | | naker | | Home | |
| b | be filed within 72 hours after death with the Maryle ital Hygiene. dother then "naturel", or items 23s or 28s-f show of other then "naturel", or items 23s or 28s-f show event, the Modical Examinations and be modified at | | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nan | ne (First, Middle, Ma | aiden Sumame) | |
| /lai | should be nd Mental marked o | | Meeking Manning Woodley | | | | Emma Ju | ıdson Kerr | - | |
| Maryland | and and sm | | 19a. Informant's Name/Relationship (Type, Print) | | | | reet and Number or Ru | | | Zip Code) |
| | s 1 and 2 f Health item 27 l | | Armand Beard, III/Son | 20h B | | | y Vista Dri | | | 1012 |
| ŏ | ges t of fit | | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from St | | | sition (Name o | | . 8. | oc. Location - City o | |
| altimore, | nit. Pa antmen ortant: injury e. | | ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puperal Service-Licensee | IAI | | remato | | .005 | Baltimore | |
| Ba | permit. I Departm Importar any injui | | Signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signat | | B | arranco | Sons, E | A. Sever | na Park 1 | Funeral Home |
| E | | | 23a. Part1. Enter the disease, or complications that cau | sed the death | n. Do not ente | 95 GOV. or the mode of | Ritchie F dying, such as cardiac | Wy Sever or respiratory arres | rna Park, | MD 21146 Approximate |
| | Pnysician | | Interval Between Onset and Death | | | | | | | |
| | /Medical | | disease or condition resulting in death) Due to (or | as a consequ | uence of): | u (i | AV ale | cen | | hours |
| | Examiner | Physician/Medical Examiner | Sequentially list conditions b. | 2005 | cle | 104 | c Vasc | ular | disease | 2 years |
| | bit ad | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | -0 | | | / | | | |
| | and I-trans | | that initiated events c. | enso of: | on_ | | | years | | |
| 8760, | death certificate be executed e attending physician and id for use as the burial-transit | | dia | med | nellitus, type 2 | | | MEANC | | |
| 687 | ficate by physical properties of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case | | d | | | | | 1900 | | 90015 |
| Вох | leath certifica attending ph for use as th | | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes | | | E | | | 23d. Date of de | alivery |
| | | | in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 0 Ultracers. Month | | | | | | | Day Year |
| P.0 | 30 == | Phys | 9 Unknown | | | | | | | |
| | w requires that the s been signed by th should be detache | Completed by F | Part II. Other significant conditions contributing to dear | h but not resu | Ilting in the un | | | 0 | 1/ | o the cause of death? |
| O | requi | | Defending to ording to | - C/1 | se, | my | - | Yes 1 □ Yes | 2 No 3 □ P | robably 4 Unknown |
| 3ec | e la has | mpl | merchen, cong | 67 W | ne | rear | (| 24a. Was an autopsy | prior to | utopsy findings available completion of cause of |
| Vital Records, | | e Col | 25. Was case referred to medical | Sath | 4,9 | Lepr | essim | performe | No 1 ☐ Yes | 2 No |
| | Physiclen: this certific ral director, | 0 8 | examiner? | atient 2 2 E | EB/Outpationt | 3□ DOA | Other: Nursing Ho | th (Check only one) | - 0 TOH - 10 | |
| | g Phys er this ieral di | L : u | 27. Manner of leath 28a. Date of | Injury | 28b. Time of | 28c. li | njury at | 28d. Describe how | | ocity) |
| | To the Hospitel or Attending Phywitin 24 hours attended to within 27 to the Funerel Director: Alter the completely filled in by the funeral | Certification: | 1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 □ Yes 2 □ No | | | | | | | |
| <u>≥</u> | | rtific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building | et, factory, offi | factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State) | | | ural Route Number, | | |
| | urs af urs af arel D | Ce | | | | | | | | |
| | To the Hospitel or Ai within 24 hours after of To the Funerel Direc completely filled in by | Medical | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | o the | | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | | |
|) | - > - 0 | | Ville, | // | - | - | -D419 | 5 | 11.2 | 0 |
| 30 Name and address of person who sompleted gause or that (them 23a) (Typp, Print) | | | | | | | | ele wills | | |
| | l' | | poseccitionMI | 186 | 0/U | exer | ansthig | hwa | y' MI | 221108 |
| | Sta Registr | re | NOV 0 9 2005 | istrar's Signat | are As | A) | | 1 | <i>†</i> | |

State of Maryland / Department of Health and Mental Hygiege Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician George Roosevelt Butts Month Nov 6 2005 0829 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F Director 227-20-6592 Feb 6 1928 Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County Itema 23a or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at Completed by Funeral Director Maryland Calvert Huntingtown 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 680 Verda Lane 20639 United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itema 23s 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XX:es 2 No If Yes, Give 1953 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 ☐XNo Specify: 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mesonry construction traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Butts Martha Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Shields 680 Verda Lane Huntingtown MD 20639 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 11 2005 20a. Method of Disposition 20c. Location - City or Town, State 5 1 XBurial 2 Cremation 3 XRemoval from State permit. Page Department of Important: If any injury or once. Emporia Virginia Macedonia Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home BKausc 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Pulmenary Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease, Rona 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2010 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After thi completely filled in by the funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DRIVE, SUITE 310 FREDERICK, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 HOSPITAL GL YMIS MOODY 31. Date filed (Month, Day, Year) 32. Registras Signature State 2005▶ Registrar

State of Maryland / Department of Health and Mental Hygiege 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5,2005 **Physician** Booth 3:15 A Rebecca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ VF 213-54-6913 100 Sept.9,1905 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No 0wings Director Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 155 Skinners Turn Road 20736 USA Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygene.
ans. If ifen 27 is marked other than "natural, or itema 23s and other fraumatic event, the Madical Experient matury or other fraumatic event, the Madical Experient mature. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√DXNo Specify: Black 3 ¼ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Wills Lillie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest Booth/Son 4706 Davis Ave. Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Mt. Hope UMC Cem. 11/12/05 Sunderland, MD 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licensee Gladin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10/23/01 **Physician** /Medical Due to (or as a consequence of): Examiner DODOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Giongome 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No Impatient 2 ER/Outpatient 3 DOA this s after death.

I Diractor: After this id in by the funeral d 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO027189 mmorses MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD BOX 807 31. Date filed (Month, Day, Year) 32. Registras Signature State 2005▶ Registrar

| | | | 1 - For State Registrar | State of Mar | yland / Depa <i>Cel</i> | artment of H | lealth an Death | | giene () | 05 | 38325 |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------|------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------|----------------------|--------------------|---------------------------------------------|------------------|--------------|-----------------------------------------------|
| J. | غهر | /th | 1. Decedent's Name (First, Middle, Las | t) | | | | 2. Date of De | ath Day | Year | 3. Time of Death |
| | ysicia 1edic | | Robert Paul Boyn | ton | | | | Novembe | | | 4:25 ^P м |
| | amin | | 4a. Fecility Name (If not institution, give | street and number) | | 4b. City, Town, or | Location of E | Death | 4c. Cou | unty of Deat | h |
| | 7 | 3 | Shady Grove Adven 5. Social Security Number 6. Se | | | Rockvill | | Hrs 0 Day of Di | Mon | tgome | |
| Fund | | | , | X M 2□F 7. Age (| In yrs. last birthday) Yrs. | Months Days | | Hrs. 8. Date of Bir (Month, Da 10/01/1 | 10, Year) 927 | Co | thplace (State or Foreign puntry) .igan |
| 7: | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | Usual Residence of Decedent | 70 | | | 1 | 10/01/1 | 721 | 111011 | |
| nylan | 3 | | 10a. State 10b. County | | Oc. City, Town or Lo | cation | | | | | 10d. Inside City Limits |
| se Ma | | Director | Maryland Montgome | ry | lockville | | | | | | 12C2Yes 2 No |
| with th | d d | 2 | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen | | ountry? |
| eath va 23 | 1 | Funeral | 810 Reserve Champi | on Drive 12. Was Decedent Eve | er in II S 13) | 20850 | | 2 (Specify Vas or No | U.S.A | | nican Indian. |
| iter d | No. | Fun | 1 ☐ Never Married 25☑ Married | Armed Forces? | | f Yes, specify Cuba | in, Mexican, P | ? (Specify Yes or No Juerto Rican, etc.) | ł | Black, White | e, etc. |
| U3C | EXE | ρ | 3 ☐ Widowed 4 ☐ Divorced | 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: | *************************************** | 1 ☐ Yes 2🙀 No | Specify: | | Spe | ecify: Wh | ite |
| C 27275-0036 filed within 72 hours after death with the Maryland Hygiene. sther than "natural, or Itema 23a or 28a-f ehow | lical. | Completed | 15. Decedent's Ed (Specify only highest gra | ucation de completed) | (Give | ient's Usual Occupa | during most of | f working | 16b. Kind o | of Business/ | Industry |
| F 6 fg | 2 | du | Elementary/Secondary (0-12) | College (1-4or 5+) | life. I | DO NOT use retired | 1) | | | | |
| filed w Hygien | event, the Mudical | | 17. Father's Name (First, Middle, Last) | 5+ | Prof | essor | 19 Mothade | Name (First, Middle | | rsity | |
| Maryiand 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 27 is marked other than "natural, or | 0 0 | o Be | Lew H. Boynton | | | | | | , Maidell Sull | raine) | |
| shoulk nd Me | matic | ř | 19a. Informant's Name/Relationship (7 | vpe, Print) | 19b. Mailin | ng Address (Street a | | a Stucki or Rumal Route Numb | er. City or To | wn. State. 2 | Zip Code) |
| Ma Ind 2 s Ilth ar 27 is | rtra | 1 | Dolores Marie Boyn | | | | | n Drive,Ro | | | |
| Baltimore, Maryland 21 permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien Important: If Item 27 is marked other th | othe | i | 20a. Method of Disposition | | 20b. Place of Disno | | | Date | | | Town, State |
| Page Page Int: If | لہ نہ | | 1 ☐ Burial 2 ♣ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | - | - | | /10/2005 | Brents | t book | AD: |
| Baltimore, bermit. Pages 1 av Department of Hea | y In | | 21. Simplure of Luneral Service Licen | | 22 | . Name and Addres | ss of Facility | Simple Tr | ibute 1 | Funera | al Home |
| n 885 | E 8 | | Lally Les | uliling | 10 | 040 Rockv | ille P | ike Rockv: | ille,M | 2085 | 52 |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | olications that caused the | e death. Do not ent | er the mode of dyin | g, such as car | rdiac or respiratory a | rrest, | | Approximate Interval Between |
| Physic | | | Immediate Cause (Final disease or condition | a. Lymphon | ma | | | | | | Onset and Death 6 Month |
| /Medi Exami | | | resulting in death) | Due to (or as a o | consequence of): | | | | | | |
| · . | | - | Sequentially list conditions, if any leading to immediate | b. Due to or as a c | conse uence of : | | | | | | |
| uted | ansit | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | |
| U, exec | | | resulting in death) Last | c. Due to (or as a c | consequence of): | | | | | | |
| 8 / 60, ate be executed hysician and | he bu | dical | | d. | | | | | | | |
| | | Med | IF FEMALE: | | | | | | | | |
| Geath certific e attending p | or us | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 Live birth 21 | Fetal death 3 | Ectopic pregnancy | | | | Date of deli | ivery Day Year |
| . 0 0 | thed f | yslc | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 Pregnant at tin 9 Unknown | ne of death 5∟ | Other (specify) | | | 1 | | , |
| – ž g. | 0 1 | | Part II. Other significant conditions co | ontributing to death but i | not resulting in the u | nderlying cause give | en in Part I. | 23e. Did t | obacco use c | ontribute to | the cause of death? |
| rds, puires | | d by | | | | | | 10 | Yes 2X∑No | 3 ☐ Pr | obably 4 Unknown |
| VITAL RECORDS, sician: The law requires t certificate has been signed. | should | Completed | | | | | | 24a. Was | an 24 | b. Were au | topsy findings available |
| The lav | age | Eo | | | | | | autop perfo | rmed? | death? | completion of cause of |
| VITAL Ician: Th certificate | 5 | Bec | 25. Was case referred to medical examiner? | | | | 26. Place of | Death (Check only of | | | 563170 |
| F y | | ဂ္ | 1 ☐ Yes 2 ☒ No | Hospital: 1X Inpatient | | | 4 🗀 Nursii | ng Home 5 Resi | dence 6 🗆 | Other (Spec | cify) |
| | unera | on: | 27. Manner of Death 1 ☒ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Y | 'ear) 28b. Time of Injury | Work | | 28d. Describe | how injury oc | curred | |
| OIVISION or Attending ifter death. Director: After | the f | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be | | - At home, farm, str | | Yes 2 No | 29f Location (| Street and Mu | umbar ar Di | ıral Route Number, |
| DIVISION I or Attending after death. Director: After | in by | ertif | 4 Homicide determined | building, etc. (| (Specify) | eet, ractory, office | | City or To | | mber or Au | rar noute ivumber, |
| Spit | ≝ | al C | 29a. Certifier 1 ☐ Certifying Ph | ysician: To the best of r | my knowledge, death | occurred at the tim | ne, date and p | lace, and due to the | cause(s) and | manner as | stated. |
| To the Ho within 24 h To the Fu | completely | edical | (Check only 2 Medical Exert | niner: On the basis of ex and manner state | xamination and/or inv | estigation, in my op | oinion, death o | occurred at the time, | date and place | e, and due | to the cause(s) |
| To the To the | COM | Ž | 29b. Signature and title of certifier | | | 29c. License | | | 29d. Date sig | ned (Monti | h, Day, Year) |
| | | | Marsandal | MICO | D | 15 | 1616 | | Hovemb | 4 04 | ,2005 |
| 10+1 | | | 30. Name and address of person who | | | * | | | | | |
| 1 - A | | | Nelson Kalil, MD 18 31. Date filed (Month & Day, Year) | 111 Prince 32. Registrar's | Philip Dr | ive #327 | Olney, | MD 20832 | | | |
| Re | Sta gistra | | | 2005 | s Signature | parte | | | | | |

| | | • | 1 - For State Registrar | Olaro or ma | Cei | tificate of | Death | ornar rry | Reg. No. | 105 | 30320 |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------|------------------|-----------------------------|------------------------------------------------|
| | Dhusisi | W | 1. Decedent's Name (First, Middle, La | ist) | | | | 2. Date of De | eath Day | Year | 3. Time of Death |
| | Physici /Medic | | WILHELMINA | | BOWIE | | | Nov. | 5, 2 | 2005 | 12:50A M |
| | Examin | er | 4a. Facility Name (If not institution, given | | | 4b. City, Town, o | or Location of Death | | 4c. Co | unty of Death | 1 |
| 77.00 | | | Holy Cross Ho 5. Social Security Number 6.5 | ospital 7. Age | (In use least high day) | Silve If Under 1 Year | r Spring | 8. Date of Bi | Mo | ntgom | |
| | Funeral Director | | | | (In yrs. last birthday) 67 Yrs. | Months Days | Hours Min. | Month, Di | ay, Year) | 9. Birth Cor | iplace (State or Foreign intry) LSh , DC |
| ijk. | - 6 | | 216-46-1055 Usual Residence of Decedent | | | | 1 | Aug. Z | 2,193 | o wa | isii, DC |
| | yland | | 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | | 10d. Inside City Limits |
| | e Ma | ctor | MD Montge | omery | Wheat | on | | | | | 1 □XLes 2 □ No |
| | or 28 | Olre | 10e. Street and Number | 2 | | 10f. Zip Code | 0000 | | _ | of What Cou | • |
| | ath w | Funeral Director | 12011 Dalewoo | | | | 0902 | | | J.S.A. | |
| | er de Item | nue | 11. Marital Status | 12. Was Decedent E- Armed Forces? | ver in U.S. 13. 1 | Was Decedent of I f Yes, specify Cub | Hispanic Origin? (Spe an, Mexican, Puerto F | cify Yes or No Rican, etc.) | 0- 14. | Race - Amer Black, White | |
| 36 | rs aft | Dy F | 1 A Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2X No If Yes, Give Year or Dates: | | 1□Yes 2⊡¥No | Specify: | | Sp | pecify: B | lack |
| နှ | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Itema 23a or 28a-f ahow aumetic avant, the Madical Exama or out the multified at | Completed by | 15. Decedent's E | ducation | 16a. Dece | ient's Usual Occup | pation | | 16b. Kind | of Business/Ir | ndustry |
| 212 | hin 7 P. Neti | ple | (Specify only highest grant Elementary/Secondary (0-12) | College (1-4or 5+ | | | during most of workingd) | ng | | | |
| 7 | ad wil | Con | 10th | | Doi | mestic | · · · · · · · · · · · · · · · · · · · | | <u> </u> | Home | |
| ב | tal Hydral doth | Be | 17. Father's Name (First, Middle, Last | | | | 18. Mother's Name | (First, Middle | | | |
| <u>₹</u> | Men Marke Marke | ² | * | Bowie | | | | garet | | kins | |
| Z Z | 12 sh h and 7 Is n | 1 | 19a. Informant's Name/Relationship (Rita Nzuwah- | | | | and Number or Rural wood Dri | | , | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumetic | | 20a, Method of Disposition | Daugnter | | | | ate | | ion - City or T | |
| ٥ | Pages nent of I ant: If ite ury or o | | 1 ☐ Gurial 2 ☐ Cremation 3 ☐ | | 20b. Place of Dispo | | 1 7 7 /7 | | | ey, M | |
| | permit. Pag Department Important: any injury o | | 4 □Donation 5 □ Other (Special Structure of Funeral Service Lice | 11 | Norbeck | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | - | | | lome, P.A |
| Ba | permit. Departm Imports any inju | _ | A sour 1 | Lugart | | | ashingto | | | | |
| 0,5 | -g -5° g | | 23a. Part1. Enter the disease, or com shock, or hear failure. List only | plications that caused t | | | | | | | Approximate |
| 4 | Physician | | Immediate Cause (Final | | | | LEAR PAL | | | | Interval Between Onset and Death |
| P. | /Medical | | disease or condition resulting in death) | _ a | consequence of): | 1141 1100 | - HILL 1111 | <u> </u> | | | |
| - 4 | Examiner | | Consideration and a constitution | TYPE I | I DIABET | ES | | | | | |
| | p # | Iner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a HYPERT | consequence of): FNSTON | | | | | | |
| | and trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. | | | | | | | |
| 50, | cien a | | resulting in doubly East | | consequence of): SON S DI | C F A C F | | | | | |
| 68/60, | icate be executed physicien and s the burial-transit | Medical | | d. HILLIA | DON D DI | DIMOT | | | | | |
| | E 00 00 | | IF FEMALE: | 23c. If yes, outcome o | f pregnancy | | | | 224 | . Date of deliv | 100/ |
| ROX | eath ce attendii for use | Physician/ | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No | 1☐Live birth 2 4☐Pregnant at ti | Fetal death 3 | Ectopic pregnanc Other (specify) | у | | 230 | Month Month | Day Year |
| o. | by the a | hysi | 9 Unknown | 9□ Unknown | | | | | | | |
| ري. ح | law requires that the as been signed by th 2 should be detache | by P | Part II. Other significant conditions | contributing to death but | not resulting in the ur | nderlying cause giv | ven in Part I. | 23e. Did | tobacco use | contribute to f | the cause of death? |
| Vital Records, | w require been sig should b | | | | | | | 1 🗆 | Yes 2□N | lo 3 🗆 Pro | bably 4 🕱 Unknown |
| ပ္က က | aw re | Completed | | | | | | 24a. Was | | 4b. Were aut | opsy findings available |
| Ĭ | 0 5 0 | E O | | | | | | auto perfo | ormed? 2XI No | death? | empletion of cause of |
| Ta | ician: Th certificate rector, pag | Bec | 25. Was case referred to medical examiner? | | | | 26. Place of Death | | | | |
| o 5 | hysic this ce al dire | 2 | 1 ☐ Yes 2 ₹ No | Hospital: 1 Inpatien | | | 4 Nursing Hon | ne 5□Resi | dence 6 | Other (Speci | fy) |
| ב כ | Attanding Physician: r death. ector: After this certific by the funeral director. | ë E | 27. Manner of Death 1 X Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day | Year) 28b. Time of Injury | 28c. Injui Wo | | 8d. Describe | how injury or | curred | |
| <u>s</u> | r Attand er death rector: / | cat | 2 Accident investigation 3 Suicide 6 Could not be | | Address from the | | Yes 2 No | 06 1 1 | 2 | | |
| Division | lor At after of Direction by | Certification: | 4 ☐ Homicide determined | | y - At home, farm, str (Specify) | eet, factory, office | 2 | City or To | | umber or Rur | al Route Number, |
| _ | spita ours naral filled | | 29a. Certifier 1 X Certifying PI | nysician: To the best of | my knowledge death | occurred at the ti | me date and place of | nd due to the | Called(e) | d manner ac | hatet |
| | B Hos 24 h B Fur etely | edical | (Check only 2 Medical Examone) | miner: On the basis of and manner state | examination and/or inv | estigation, in my | ppinion, death occurre | d at the time, | date and pla | ce, and due t | o the cause(s) |
| | To the Hos within 24 h To the Fur completely | Me | 29b. Signature and title of certifier | | | 29c. Licens | se number | | 29d. Date si | igned (Month, | Day, Year) |
|) | | | > Groupe | Sulveny | 2 | D5 | 6691 | | Nove | mber | 5, 2005 |
| | | 1 | | | | 1 | | | | | - |

Registrar
DHMH 17 Rev 1/2001

State

MD 12107 Heritage Park Cir Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ghousia Sultana,
31. Date filed (Month, Day, Year)
NOV 0 9 2005

| | | 1 - State Registrar | State of Marylar | | ertificate of L | | | ene 0 0 5 | 38327 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------|-----------------------------------------|-----------------------------------------------|----------------------------------------------|-------------------------------------|
| | | Decedent's Name (First, Middle, Last | it) | | | | 2. Date of Death | | 3. Time of Death |
| Physici /Medic | | Preston Arnold | Beach | | | | Novembe | RII 200 | 5 11-10 AM |
| Examir | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, or | Location of Deat | h | 4c. County of Dea | ath |
| | | Anchorage Nursing | Home | | Salisbu | | | Wicomico | |
| Funeral | | 5. Social Security Number 6. S | 7. Age (In yrs. | | Months Days | If Under 24 Hrs. Hours Min. | | Year) 9. Bi | rthplace (State or Foreign ountry) |
| Director | | 221-26-0012 | 62 | Yrs. | | | 09-14-19 | 943 Del | aware |
| and * | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or I | ocation | | | | 10d. Inside City Limits |
| Manyl f sho | ō | MD (C | | | | | | | 1 XYes 2 No |
| with the Marylan a or 28a-f show the notified at | Director | MD Somerset 10e. Street and Number | : we | nona | 10f. Zip Code | | 10 | og. Citizen of What C | ountry? |
| 3a or | | 22992 Parkinson | Road | | 2182 | 2.1 | | USA | |
| be filed within 72 hours after death with the Maryland lal Hygiene. do other then "natural", or Itams 23a or 28e-f show event, its Medical Exain inclinate incillinate. | Funeral | 11. Marital Status | 12. Was Decedent Ever in U | J.S. 13 | . Was Decedent of His If Yes, specify Cubar | | Specify Yes or No- | 14. Race - Am | erican Indian, |
| after or Ita | | 1 ☐ Never Married Married | Armed Forces? 1 ☐ Yes 2 No | | - No | | to Hican, etc.) | Black, Wh | |
| all. | by | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 □ Yes 2 No | Specify: | | Specify: | White |
| natur | Completed | 15. Decedent's Ed (Specify only highest gra | | 16a. Dec | edent's Usual Occupa re kind of work done d | ition furing most of wo | rking | 16b. Kind of Business | s/Industry |
| ithin ithin | ldu | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired) |) | | | |
| ygier ygier tr | Cor | 12 | none | Conti | actor | 40. 84-45-4-81- | | lome Impro | vement |
| be filed within 72 hatal Hygiene. | Be | 17. Father's Name (First, Middle, Last) | | | | | me (First, Middle, M | taiden Sumame) | |
| should ind Men marks | 2 | Sorn Beach | | 1 | | Mary Br | | | 7.0.41 |
| 12 sh h and 7 is n | | 19a. Informant's Name/Relationship (Stella Louise Be | | | ling Address <i>(Street</i> a 2 Parkins (| | | • | ZIP Code) |
| 1 and 1 and 1 ealth om 27 ther tr | | 20a. Method of Disposition | | | position (Name of | on Road, | | 20c. Location - City o | Town, State |
| Pages nent of h | | 1⊠Burial 2 ☐ Cremation 3 ☐ | Removal from State | cemetery, cr | ematory or other place | 1 | | | |
| t Pa rtmer rtant | | *4 ☐Donation 5 ☐ Other (Specifical Signature of Funerative Service Licer | | | S U.M. Cer | | 5/2005 W | Enona, Ma | ryland |
| permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Agges. | | Signature of Funeral Service Licer | . () | Hi | nman Funer | ral Home | | | |
| | | Base Part 1 Fotor the disease or com | MO029 | | 673 Somers | set Ave. | , Princes | s Anne, M | D 21853 Approximate |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | A | EL A | | | | | Interval Between Onset and Death |
| Physician | 6 | Immediate Cause (Final disease or condition resulting in death) | a | MAC | CAKU | IALI | NFAR | C110N | 1 Hour |
| /Medical Examiner | | 1 | CARDIO | | ONTILY | | | | 24EARS |
| | - | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a conse | quence of): | | | | | |
| ted | Examiner | Cause (Disease or injury | INSULIN | DE | PENDER | ST DIF | ABETES 1 | MELLITUS | 25 YEARS |
| be executed sician and burial-transit | xar | that initiated events resulting in death) Last | Due to (or as a conse | | | | | | |
| Sicial Sicial Duri | dlcal | l | d | | | | | | |
| fficate g phys | edic | | <u> </u> | | | | | | |
| death certifica attending ph | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregn | | Os., | | | 23d. Date of de | elivery |
| that the death cer ed by the attendir detached for use | icla | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1□Live birth 2□Fet 4□Pregnant at time of | | ☐ Ectopic pregnancy ☐ Other (specify) | | | Month | Day Year |
| of the ache | hys | 9 Unknown | 9□ Unknown | | | | | | |
| uires tha | by P | Part II. Other significant conditions of | | sulting in the | underlying cause give | n in Part I. | 23e. Did tob | acco use contribute l | o the cause of death? |
| quire an sig uld b | | PNENMO | | | | | 1 ☐ Ye | s 2□No 31211 | robably 4 Unknown |
| aw requir | plet | END STI | AGE REN | IAL | DISE | ASE | 24a. Was an | | utopsy findings available |
| The la | Completed | | | | | | autopsy perform | ned? death? | completion of cause of s 2 □ No |
| an: tiffica tor, p | a | 25. Was case referred to medical | | | | 26. Place of Dea | ath (Check only one | | 20110 |
| ysici ysici is ce direc | To B | examiner? 1 Yes 2 No | Hospital: 1 Inpatient 2 |] ER/Outpati | ent 3 DOA Othe | F: 4 Wursing H | lome 5 ☐ Reside | nce 6 Other (Spe | ecify) |
| ter th | | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time Injury | | at | 28d. Describe ho | w injury occurred | |
| ath. | Certification; | 2 Accident investigation | 1 | | | res 2 □ No | | | |
| r Atte | tific | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Place of Injury - At I building, etc. (Spec | nome, farm, s | street, factory, office | | 28f. Location (Str. City or Town, | eet and Number or F , State) | Rural Route Number, |
| rs aft al Di | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | ledical | 29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar | ysician: To the best of my kn niner: On the basis of examin and manner stated. | owledge, de ation and/or | ath occurred at the tim investigation, in my op | e, date and place pinion, death occu | e, and due to the ca urred at the time, da | use(s) and manner a ite and place, and du | s stated. e to the cause(s) |
| To th withir To th comp | Me | 29b. Signature and title of certifier | Yal In | . 14 | 29c. License | | 29 | d. Date signed (Mon | th, Day, Year) |
| | | 20.11 | | , | | 46 | 1621 | JONEWB | SER 14,2005 |
| | | 30. Name and address of person who M. SHIRAZI, | M.D. PEN | N Su | -A REGI | ONAL | MEDICA | L CENTER | MD21081 |
| | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | nature | | | | | |
| Regist | | NOV 1 6 | 2005 Jeen | D. | good | | | | |

05-7446 B.K.S MICHAEL L. BRODERICK

Funeral

Director

or 28a-f show

Items 23a

naturel', or

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic event, ITE ODGE.

Physician /Medical

Examiner

the burial-transit

attending p as

After this funeral c

Director:

death.

To the Hospital within 24 hours a To the Funeral C

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2005 **Physician** Year Michael Lawrence Broderick NOV. 0015 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES 6101 MAIN STREET LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days, Hours Min. 10/15/1953) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 □ M 2 🖔 F 220-56-5193 52 Yrs Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Completed by Funeral Director Prince Georges Maryland Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20706 6101 Main Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Machinist Self Employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Broderick Jean Elizabeth Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda K. Broderick/ Former Wife 2524 Ayr Court Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removat from State 4 □Donation 5 □ Other (Specify) Huntt Crematory 11/10/2005 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Gunshot wound to Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1 X Yes 2 ☐ No 25. Was case referred to medical examiner?
1∑ Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural subject was shot 1 ☐ Yes 2 No 23:45 PM 2 Accident 11-4-05 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 6101 Main Street Street mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Whadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 0 8 2005

Ai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature & Speek O.C.M.E

111 PENN STREET, BALTIMORE, MARYLAND 21201

5, 2005

NOV.

State of Maryland / Department of Health and Mental Hygiene Reg. No. UU5 Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month 12ay **Physician** 2005 1:20 AM Erma Lillian Brode /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Allegany Frostburg, MD St. Vincent DePaul Nursing Center 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 M 202 F 13-Feb-1919 Maryland 86 215-14-6280 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" and injury or other traumatic avairable. 10c. City, Town or Locetion 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No Funeral Director Midlothian Maryland Allegany 10e. Street end Number 16007 Ritchie Ridge Lane, SW 10f. Zip Code 10g. Citizen of What Country? 21543-U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married Specify: White 1□Yes 2V No Specify: ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unknown Flora Duncan 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P. O. Box 389 A. Fay Stanton daughter Midlothian Maryland 21543 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 14-Nov-2005 Frostburg Frostburg Memorial Park Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Durst Funeral Home, 57 Frost Ave., Frostburg, MD 215 olin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical CONGESTIVE HEART FAILURE Examiner Due to (or as a consequence of):

APTENTOS CLETTOTIC CARDIO ASSCULON

Due to (or as e consequence of):

Oue to (or as e consequence of): Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth Natural 2 Accident 5 Pending 1 ☐ Yes 2 No 24 hours efter death. investigetion 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 00013166 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 48 Tan Tennoce Fros Mura nRs 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

31. Date fileg

| | | | State of Maryland / Di | epartment of Health and M | • | • | |
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| | | | 101 | Certificate of Death | Reg. | 2005 | 38330 |
| | | | Decedent's Name (First, Middle, Last) | | 2. Date of Death | Day Year | 3. Time of Death |
| | Physicia /Medic | | James Earl Cogley | | November | | 10:02 P M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Dear | |
| | | | Garrett County Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth | Oakland day) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Garr | |
| | Funeral Director | | 4574 0015 | Months Days Hours Min. | (Month, Day, Ye | ar) 9. Bill 1943 Ma | thplace (State or Foreign ountry) |
| Н | ס | | Usual Residence of Decedent | | 11.521 17, | 23.0 | |
| | anylar | ٦Ľ | 10a. State 10b. County 10c. City, Town | | | | 10d. Inside City Limits 1 ∑ Yes 2 ☐ No |
| | the M | ecto | MD Garrett 10e. Street and Number | Oakland 10f. Zip Code | 100 | Citizen of What Co | |
| | 3a or | Funerai Director | 710 Oakland Drive | 21550 | 109. | US | |
| | death | nera | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- | 14. Race - Ame | erican Indian, |
| Ď | or Ite | / Fu | 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☑ No Specify: | nican, etc.) | Black, Whit | e, etc. White |
| 213-0030 | be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23a or 28a-f ahow avant, I' a McAlcal Execut at man be redified at | ed by | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | Decedent's Usual Occupation | 405 | 100 | |
| 2 | in 72 | Completed | (Specify only highest grade completed) | recedent's usual Occupation Give kind of work done during most of work life. DO NOT use retired) | ing 160 | . Kind of Business | Industry |
| 7 | d with giene. | lmo: | Elementary/Secondary (0-12) College (1-4or 5+) 4th | Janitor | 1 | Business | es |
| Jalla | al Hy d othe | Be C | 17. Father's Name (First, Middle, Last) | 18. Mother's Name | e (First, Middle, Maid | | |
| 7 | ould to Ment Marka Marka Maric a | 2 | Ray Ellsworth Cogley | Mamie | Florenc | | 127 |
| 2 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Items 29a or 28a-f show any injury or other traumatic avant, it a Medical Exercit at marter traumatic avant, one. | | | Mailing Address (Street and Number or Run | | | Zip Code) |
| ย์ | Heal Heal tam 2 | | 20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. | 51 Hutton Road, Oak | | Location - City or | Town, State |
| pailillore, | Pages ent of nt: If i | | 1 to Burial 2 Cremation 3 Elemoval from State | crematory or other place) Co. Mem. Gdns 11/ | 15/2005 | akland, | Maruland |
| 2 | permit. Departm Importa any inju | | 21. Signature of Funeral Service Licensia | 22. Name and Address of Facility | | S. Second | |
| <u> </u> | 205 20 | | Seading Man | Stewart Funeral Ho | ne Oakl | and, Md. | 21550 |
| | | | 23a. Part1. Enter the disease, Ir complications that caused the death. Do no shock, or heart failure. List only one cause on each line. | t enter the mode of dying, such as cardiac | or respiratory arrest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | 3 | Immediate Cause (Final disease or condition resulting in death) Acute Myocardi | | | | Sudden |
| | Examiner | | Due to (or as a consequence of | | | | Years |
| | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | rt railure | | | iears |
| | ocuted nd transii | Examiner | that initiated events | | | | |
| ,007 | be executed ician and burial-transit | cal Ex | resulting in death) Last Due to (or as a consequence of |): | | | |
| 100 | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit | - | d | | | | |
| YOU | n certii inding use a | Physician/Med | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | • 500 | | 23d. Date of del | ivery |
| Ď | death ne atte | sicia | in the past 12 months? 1 Yes 2 No No No No No No No No No No | 3 ☐Ectopic pregnancy 5 ☐ Other (specify) | | Month | Day Year |
| 5 | at the | Phys | 9 Unknown | | T == =: | | |
| ń | The law requires that the death certificate attending phys page 2 should be detached for use as the | by | Part II. Other significant conditions contributing to death but not resulting in t Diabetes Mellitus | ne underlying cause given in Part I. | 1 Yes | | the cause of death? |
| necorus, | v requ been should | etec | | | 24a. Was an | Ţ | - // |
| ב ב | he lav e has age 2 | Completed | | | autopsy performed | prior to death? | topsy findings available completion of cause of |
| N I G | an: T | യ | 25. Was case referred to medical | 26. Place of Death | 1 Yes 2 (Check only one) | No 1 LI Yes | 2□ No |
| 5 | Attending Physician: The lav r death. sector: After this certificate has by the funeral director, page 2 | To B | examiner? 1 Yes No Hospital: 1 Inpatient ER/Outp | atient 3 DOA Other: 4 Nursing Ho | me 5 Residence | 6 ☐Other (Spec | city) |
| 5 | ing PI | | 27. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Tir | ury Work? | 28d. Describe how in | ijury occurred | |
| VISION | death death ctor: / the f | icat | 2 Accident investigation 3 Suicide 6 Could not be | M 1 Yes 2 No | 28f. Location (Street | and Number or Ri | Im I Route Number |
| 2 | after after Dirac | Certification: | 4 Homicide determined building, etc. (Specify) | r, stroot, ractory, office | City or Town, St | afe) | na riode reditiber, |
| | ospita hours unara ly fille | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, | death occurred at the time, date and place, | and due to the cause | (s) and manner as | stated. |
| | To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completely filled in by the fun | ledicai | (Check only 2 Medical Examiner: On the basis of examination and/one) | | | | |
| | 7 Milt | Σ | 29b. Signature and title of certifier | 29c. License number | 29d. I | Date signed (Month | |
| | / | | 30 Name and additional agency who completely and it will be an active to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont | D23979 | | 11/12/20 | JU2 |
| | Q | | 30. Name and address of person who completed cause of death (Item 23a) (TDr. Robert Goralski, MD 311 N. F | ourth St., Oakland, | Marvland | 21550 | |
| ×. | Sta | te | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | <i>y</i> = | | |
| | Registr | aŕ | NOV 1 5 2005 | books | | | |

State of Maryland / Department of Health and Mental Hygierie 0 0 5 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Yes
November 14, 2005 **Physician** 8:25 A. M Ruth Doub Clise /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Westernport Moran ManorNursing Home Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F Maryland Yrs 219-46-0696 August 22, 1914 Director Usual Residence of Decedent 10d. Inside City Limits withIn 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State show ir than "natural", or Itams 23a or 28a-f shov The Medical Examiner must be notified at 1 ☐ Yes 2 No Director Lonaconing Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21539 15701 Lower Georges Creek Road S.W. U.S.A. Funeral 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic avent. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Concrete 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillian Grace Beckley Edward Calvin Doub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia L. Clise-Daughter 15701 Lower Georges Creek Road S.W., Lonaconing, Maryland, 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November ☐ Burial 2 Cremation 3 ☐ Removal from State Cumberland Crematory Cumberland, Maryland 15, 2005 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeal Home P.A., 8 East Main Street, 21. Signature of Funeral Service Licensee McKe ٤. Lonaconing, Marviand, 21539 Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebron 1 Yes 2 No 3 Probably been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate Bili 1 ☐ Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 2 ER/Outpatient 1 Inpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Matural 2 Accident 5 Pending 1 🗌 Yes 2 □No death. investigation Diractor: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To tha Hospital or At within 24 hours after d 4 Homicide 29a. Certifier 🗺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 BROAD H. TAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 1 2005 Registra

Edward

ar/son,

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** NATLEE 10:15 pm CAESAR Oct. 30, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hospital Cheverly
If Under 1 Year If Under 24 Hrs. Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2½ P 241-36-9306 85 Yrs. Apr.10,1920 S.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Y☐ Yes 2 ☐ No Director MD Prince Georges Landover with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8208 Sheriff Road 20785 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12 Homemaker othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked ot James Marcus Florence Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jezebell Chapman Sister 8208 Sheriff Rd.Landover, MD.20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Fort Lincoln Cem 11/7/2005 Brentwood, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arkria devote Cardiovasalar Disea Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 € 1 0 Year Month Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Myll, tas abetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Dement autopsy performed' 1□ Yes 2 No Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \((Specify) \) 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: Co. at be determined ot be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital on within 24 hours at To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3 November 1,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbay Rd Hy attsuite MD 20181 DEVERTE MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2005 Registrar

| | | 1 - For State Ragistrar | State of Ma | | d / Depa | | lealth and | Mental Hy | giene | 05 | 3833 | L. |
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| o | | Decedent's Name (First, Middle, Las | t) | | | | | 2. Date of Dea | ith | | 3. Time of Dea | |
| Physic /Med | | David A. Cival | i | | | | | Month Novem | Day Der 9, | Year 2005 | 3:30 p | М |
| Exami | | 4a. Facility Name (If not institution, give | street and number) | | | 4b. City, Town, or | Location of Dea | | | nty of Death | | |
| | | 2705 Henderson A | venue | | | Silver | | | Mont | gomer | | |
| Funera | _ | 5. Social Security Number 6. Security Number 5. Security Number 6. Security Number 5. Security Number 6. Security Number 5. Security Number 6. Security Number 5. Security Number 6. Security Number 6. Security Number 5. Security Number 6. Security Number 6. Security Number 6. Security Number 5. Security Number 6. Security Number 5. Security Number 6. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Security Number 5. Sec | 7. Age | e (In yrs. i 48 | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hi Hours Mir | s. B. Date of Birt (Month, Da | Year) 1957 | 9. Birth | place (State or Fo | reign |
| Director | | Usual Residence of Decedent | | | 115. | | | Jan. 20 | 1957 | Con | nécticut | |
| fand ow | | 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | 10d. Inside City Li | imits |
| Mary Ff sh | to | Maryland Montgo | mery | S | ilver | Spring | | | | | 1 □ Yes 2 | οNĒ |
| th the | irec | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen o | of What Cou | intry? | |
| hours after death with the Maryland hours after death with the Maryland turel, or items 23a or 28a-f show all Examiner must be notified at | Funeral Directo | 2705 Henderson A | | | | 20902 | | | | USA | | |
| tems | nue | 11. Marital Status | 12. Was Decedent Armed Forces? | | S. 13. | Was Decedent of H If Yes, specify Cuba | lispanic Origin? (an, Mexican, Pue | (Specify Yes or No arto Rican, etc.) | 14. R | lace - Amer lack, White | | |
| s afte | by F | Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 21☐ N If Yes, Give Year or Dates: | No | | 1 ☐ Yes 2 █No | Specify: | | Spec | _{cify:} Whi | Lte | |
| IIIG KIK 15-UUSO be filed within 72 hours after death with the Marylar ttal Hygiene. d other then "naturel, or liems 23e or 28e-f show event, the Medical Examinar must be notified at | ed | 15. Decedent's Ed | ucation | | 16a. Dece | dent's Usual Occup | ation | | 16b. Kind of | Business/I | ndustry | |
| nin 72 na 'n | plet | (Specify only highest gra | de completed) College (1-4or 5 | (+) | (Give | kind of work done o DO NOT use retired | during most of w d) | orking | | | | |
| IU CICID- stiled within 72 h I Hygiene, other then "nati | Completed | 20110112170000112177 | 5+ | | Tea | cher | | | Educat | | | |
| IMBITYIBIIG ZIZID-UUDO d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other then "naturel", or treumatic event. Ins Wedical Exam | Be (| 17. Father's Name (First, Middle, Last) | | | | | | ame (First, Middle, | | ame) | | |
| should be and Mental is marked o | L _O | Alphonse Civali | | | | - | | D. Abele | | | | |
| 2 shc and and is my | 336 | 19a. Informant's Name/Relationship (7) John Civali/ Brot | * ' | | 1 | • | | Rural Route Numbe Fremont, | | | | 1 |
| C, 1 an 1 an 1 an 2 an 2 an 2 an 2 an 2 an | | 20a. Method of Disposition | .1161 | 20b. P | - | sition (Name of | maring, | Date Date | 20c. Location | | | - |
| not of it. If it. | | 1 Burial 2 ☐ Cremation 3 ☐ | | 0 | emetery, crei | natory`or other plac rt Cemetery | . I TAO A | ember 14 | | 2000 | | |
| Dalitimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or othe | | ' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen | | | | | i | 2005 s Funeral | | | nnecticu | ıt_ |
| Dep de de de de de de de de de de de de de | | 1 | -0-0 | | 5 | rancıs J. 00 Univer | sity El | vd, W, Si | . ноте lver s | Inc Sprine | , MD 209 | 901 |
| | | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only | olications that caus | t e death | | | | | | | Approximate Interval Betwee | |
| Physiciar | | Immediate Cause (Final | | | | | | | | | Onset and Dead | |
| /Medica | | disease or condition resulting in death) | a. Respira Due to (or as | | | re | | | | - | MINUTES | |
| Examine | | Sequentially list conditions | b. Acquire | d Im | mune D | eficiency | Syndro | me | | | Years | |
| pe is | Examiner | Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | a consequ | uiance of)r | | | | | | | |
| bo, be executed sician and burial-transit | хап | that initiated events resulting in death) Last | c Due to (or as | a conseq | uence of): | | | | | | | |
| sician buria | caiE | | | , | | | | | | | | |
| > = | edic | | . d | | | | | | | | | |
| Geath certificate attending phy ed for use as the | Z | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | 75 | | | 23d. [| Date of deliv | very | |
| . 0 0 0 | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1☐Live birth 4☐Pregnant at | | | Ectopic pregnancy Other (specify) | <u> </u> | | 1 | Month | Day Year | r |
| that the de | hys | 9 Unknown | 9□ Unknown | | | | | | | | | |
| The law requires that the tee been signed by the lage 2 should be detached. | by | Part II. Other significant conditions of | ontributing to death b | ut not res | ulting in the u | nderlying cause giv | en in Part I. | | | | the cause of death | |
| w require | ted | | | | | | | - 5 | es 2MNo | 3 🗆 Pro | bably 4 Unkr | IOWII |
| HECOLDS, he law requires t e has been signe age 2 should be o | Completed | | | | | | | 24a. Was autor | sv | prior to co | opsy findings avai ompletion of cause | ilable e of |
| | Cor | | | | | | | 1 ☐ Yes | med? 2X□ No | death? | 2□ No | |
| r VICAL Prysicien: Thysicien: The sister director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | _ Oth | | eath (Check only o | | | | |
| 99 | 1. To | 1 Yes 2 No | 1 ☐ Inpatie | | ER/Outpatier 28b. Time o | | | Home 5 X Resid | | | ify) | |
| JIVISION OT I or Attending Phy after death. Director: After this in by the funeral d | tion | Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Da | y Year) | Injury | Wor | k? Yes 2⊡No | | . , | | | |
| JIVISIG or Attendati after deati Director: In by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Inj | ury - At ho | ome, farm, sti | reet, factory, office | | 28f. Location (S City or Tov | | mber or Rui | al Route Number, | |
| S afte | Cert | 4 I Hombide | building, et | с. (Эрвсп | y) | | | Only of You | n, Olale) | | | |
| UIVI To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by | | (Check only 2 Medical Exam | ysicien: To the best niner: On the basis o | fexamina | wledge, deat tion and/or in | h occurred at the tir vestigation, in my o | me, date and pla pinion, death oc | ce, and due to the curred at the time, | ause(s) and date and place | manner as | stated. to the cause(s) | |
| To the I within 2 To the I complet | Medical | one) 29b. Signature and title of certifier | and manner sta | ated. | | 29c. Licens | e number | | 29d. Date sigi | ned (Month | Dav. Year) | |
| ₽ ¥ ₽ 8 | | 1 ment | HINK | 1 | M | | 6073 | | Novemb | | | |
| 6 | | 30. Name and address of person who | completed cause of o | leath (Item | n 23a) (Type. | Print) | | | | | | |
| , | | Merril Stock, M. | | | | | shingto | n, DC 200 | 36 | | | |
| | tate | 31. Date filed (Month, Day, Year) | 32 Registr | ar's Signa | ture | alle I | | | | | | |
| Regis | trar | NOV 14 20 | US Harry | 1 | 1000 | | | | | | | |

| | | • | For Stata Registrar | State of Maryland / Dep Ce | artment of Health and rtificate of Death | Mental Hygie | | 88336 |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 決 | Physici | an | Decedent's Name (First, Middle, Last) Lucille Leasa Chaf | fin | | 2. Date of Death Month November | ^{Day} 2005 | 3. Time of Death 22:25PMM |
| | /Medic Examin | | 4a. Facility Name (If not institution, give stre AnneArundel Medica | et and number) | 4b. City, Town, or Location of Dea Gambrills | th | 4c. County of Death AnneArunde | l County |
| | Funeral Director | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birthday, 86 Yrs. | If Under 1 Year If Under 24 Hrs Months Days Hours Min | | | |
| | ryland how | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or L | ocation | | 10 | od. Inside City Limits |
| | r 28e-f | Director | Maryland AnneArund 10e. Street and Number | del Gambrill | S 10f. Zip Code | 10g. | . Citizen of What Coun | 1 ☐ Yes 2 No ry? |
| | eath wit | | 730 Maryland Rt. #3 | | 21054 | | United Stat | |
| 336 | be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or Itams 23a or 28e-f ehow event, I'm Medical Eracid and must be notified at | by Funeral | 1 Never Married 2 Married 3 Nowled 4 Divorced | Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2X No Specify: | rto Rican, etc.) | Black, White, e | etc. |
| Maryland 21215-003 | n 72 hou | Completed | 15. Decedent's Educat (Specify only highest grade of | om oleted) (Give | dent's Usual Occupation e kind of work done during most of we DO NOT use retired) | orking 16i | b. Kind of Business/Ind | ustry |
| 1212 | filed within 72 Hygiene. other then "nai | Com | 17. Father's Name (First, Middle, Last) | 5 P | Administration | ame (First, Middle, Mai | Board of Ed | lucation |
| land | | To Be | Albert Benjamin Leas | sa | | ma Ann Zool | | |
| Mary | ~ 6 5 6 | | 19a. Informant's Name/Relationship (Type, | · | ing Address (Street and Number or F | Rural Route Number, C | tity or Town, State, Zip | |
| Baltimore, I | 00 | on the second | Calvin J. Morris 20a. Method of Disposition 1 Daurial 2 Cremation 3 Per | 20b. Place of Disponyal from State | matory or other place) | Date 200 | c. Location - City or To | wn, State |
| altin | permit. Page Department Importent: II eny injury o | | 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | | O blome and Address of Facility | ouglas A. I | | |
| m T | 89558 | 1 | 23a. Part1. Enter the disease, or complications, or heart failure. List only one of | | 331 Eastern Blvd | . N. Hagers | stown Mary] | and 21742 Approximate |
| | Physician | | shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death) | _ | | | | Interval Between Onset and Death |
| 1 | /Medical Examiner | | | Due to (or as a consequence of): | my arting | Dusane | | days |
| 95 | tad nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence of): | 0 | | | |
| 8760, | cate be executed physicien and the burial-transit | | that initiated events c. resulting in death) Last | Due to (or as a consequence of): | | | | |
| Õ | ndificate ng phys s as the | Medical | IF FEMALE: | | | | | |
| O. Box | The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | □Ectopic pregnancy □ Other (specify) | | 23d. Date of delive Month | ry Day Year |
| ۵. | uires that the signed by Id be detacted | 2 | Part II. Other significant conditions contril | buting to death but not resulting in the | underlying cause given in Part I. | | cco use contribute to th | e cause of death? |
| Recor | hysicien: The law requir his certificate has been si I director, page 2 should I | Completed | | | | 24a. Was an autopsy performe | d2 prior to con death? | osy findings available inpletion of cause of |
| ā | icien: Th certificate rector, pag | 0 | 25. Was case referred to medical examiner? | | | 1 ☐ Yes 2 eath (Check only one) | No 1 □ Yes | 2 140 |
| ₹ | Ci. | 00 | | pital: | | Home 5 Residence | e 6 Other (Specify | |
| on of Vit | ing Physicie n. After this cert funeral direct | မ | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) 2 □ ER/Outpatie 28b. Time of Injury | of 28c. Injury at Work? | 28d. Describe how | injury occurred |) |
| Division of Vital Records, | ittending P death. ctor: After ti / the funera | မ | 27. Manner of Death | inpatient 2 LENOutpatie | of 28c. Injury at Work? M 1 Yes 2 No | 28d. Describe how | et and Number or Rura | |
| Division of Vit | ittending P death. ctor: After ti / the funera | Certification: To | 27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier Certifying Physic | 28a. Place of Injury - At home, farm, si | of 28c. Injury at Work? M 1 Yes 2 No treet, factory, office | 28f. Location (Stree City or Town, \$ | et and Number or Rura State) se(s) and manner as st | Route Number, |
| Division of Vit | ittending P death. ctor: After ti y the funera | မ | 27. Manner of Death 15. Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Check only 2 Medical Examinal | 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) | of 28c. Injury at Work? M 1 Yes 2 No treet, factory, office th occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred | 28d. Describe how 28f. Location (Stree City or Town, \$ 29, and due to the causeurred at the time, date | et and Number or Rura State) se(s) and manner as st and place, and due to Date signed (Month, i | Route Number, ated. the cause(s) |
| Division of Vit | ittending P death. ctor: After ti / the funera | edical Certification: To | 27. Manner of Death 15. Natural 2 | 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) | of 28c. Injury at Work? M 1 Yes 2 No treet, factory, office th occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the time, date and place of the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred | 28d. Describe how 28f. Location (Stree City or Town, \$ 29, and due to the causeurred at the time, date | et and Number or Rura State) se(s) and manner as st and place, and due to Date signed (Month, i | ated. the cause(s) Day, Year) |
|) | ittending P death. ctor: After ti / the funera | Medical Certification: To | 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 7 Medical Examinat | 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) 28c. Place of Injury - At home, farm, sibuilding, etc. (Specify) | th occurred at the time, date and plat nvestigation, in my opinion, death occurred. 29c. License number | 28d. Describe how 28f. Location (Stree City or Town, \$ 29, and due to the causeurred at the time, date | et and Number or Rura State) se(s) and manner as st and place, and due to Date signed (Month, i | ated. the cause(s) Day, Year) |

| | | 1 | State State Registrer | of Maryland / Depa | | ealth and M | lental Hygie | 2005 | 38337 | | | |
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| ı | Physicia | an | 1. Decedent's Name (First, Middle, Last) NICholas Chacera | S | | | 2. Date of Death Month | Day Year | 3. Time of Death 20:28 p M | | | |
| | /Medic Examin | er | 4a. Facility Name (If not institution, give street and Washington Adventist | Hospital | 4b. City, Town, or Taksma | Park | | 4c. County of Death | mery | | | |
| | Funeral Director | | 5. Social Security Number 5. Social Security Number 6. Sex 1.25M 2F Usual Residence of Decedent | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | tf Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day,) April 4 | (sar) 1917 ° (s | place (State or Foreign Pitry) ash, DC | | | |
| | Maryland -f show | | 10a. State 10b. County MD Montgomer | y 10c. City, Town or Lo | ver SPri | ing | | | 10d. Inside City Limits 1 Yes 2 □ No | | | |
| | n with the 3a or 28a st be noti | Funeral Director | 10e. Street and Number 8105 Eastern Ave: | nue | 10f, Zip Code 209 | 910 | 100 | g. Citizen of What Co. | untry? | | | |
| 36 | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If Health and Mental Hygiene. Itam 27 Is marked other than "natural," or Items 23a or 28a-1 show other traumatic event. If a Medical Exerciter must be notified at | | 1 Never Married 2 Married 1 Yes. | s 2XINo | Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 🏖 No | spanic Origin? (Spen, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Amer Black, White Specify: Whi | , etc. | | | |
| 21215-0036 | vithin 72 hou ne. han "natura a Madicul E | Completed by | | (Give life. | dent's Usual Occupa kind of work done d DO NOT use retired, | luring most of worki | ing 16 | N.I.S.T | | | | |
| | d be filed within antal Hygiene. cad othar than " c svant, Italie." | Be | 12th 17. Father's Name (First, Middle, Last) Charles K. Chac | conas | TIMEL | 18. Mother's Name | (First, Middle, Ma | aiden Sumame) | | | | |
| Maryland | and 2 should be saith and Mental n 27 is markad o iar traumatic sve | ပ | 19a. Informant's Name/Relationship (Type, Print) Laurel Chaconas-Da | 19b. Maiti | | and Number or Rura | al Route Number, (| | ip Code) 20814 sda, MD | | | |
| Baltimore, | 0 0 = = 1 | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify) | 20b. Place of Dispo cemetery, creation State | osition (Name of matory or other place of nrl. Sve | cs 11/3 | 20 3/05 <i>2</i> | Oc. Location - City or Alexandr: | ia, VA | | | |
| Balt | permit. Page Department of Important: If any injury or | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address of Facility Snowden Funeral House 1 and Address 2 and Address of Facility Snowden Funeral House 1 and Address 2 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 and Address 3 | | | | | | | | | |
| | Physician | | 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition | at caused the death. Do not entended and line. Mg estive Heat to for as a consequence of): | ter the mode of dying | g, such as cardiac | monary | Edema) | Approximate Interval Between Onset and Death | | | |
| 8760, | rires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit | Ilcal Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | to (or as a consequence of): to (or as a consequence of): to (or as a consequence of): | Infarc | tion | | | 3 days | | | |
| P.O. Box 68 | The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as It | Completed by Physician/Med | in the past 12 months? | | Ectopic pregnancy Other (specify) | | | 23d. Date of deli Month | very Day Year | | | |
| | uires that i signed by | d by Ph | Part II. Other significant conditions contributing t | o death but not resulting in the u | ınderlying cause give | en in Part I. | 23e. Did toba | ncco use contribute to | the cause of death? | | | |
| I Records, | | Complete | Hypertension | | | | 24a. Was an autopsy performs | 24b. Were au prior to death? No 1 Yes | topsy findings available completion of cause of | | | |
| f Vital | ding Physician: The lav h. After this certificate has funeral director, page 2 | To Be | 25. Was case reterred to medical examiner? 1 \sum Yes 2 No Hospital: | Inpatient 2 ☐ ER/Outpatient | nt 3 DOA Othe | | h <i>(Check only one)</i> me 5 ☐ Residen |) ice 6 □Other (Spec | cify) | | | |
| Division of | Attanding Physician: r death. ector: After this certification of the funeral director. | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 28e Pt | ate of Injury ### Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annu | M 1 | Yes 2 □No | | eet and Number or Ru | ral Route Number, | | | |
| Div | To the Hospital or Attandir within 24 hours after death. To tha Funaral Director: All completely filled in by the fu | Certi | | uilding, etc. (Specify) the best of my knowledge, deal | th accurred at the tim | ne date and place | City or Town, | | ctated | | | |
| | the Hos hin 24 hc tha Fun mpletely | Medical | (Check only 2 Medicet Examiner: On the and n | e basis of examination and/or in nanner stated. | vestigation, in my op | oinion, death occur | red at the time, dat | te and place, and due | to the cause(s) | | | |
| | wit To | | 29b. Signature and title of certifier Security | 3 3 4 40 | | | | | | | | |
| | 12 | | 30. Name and address of person who completed of Scan S Saedi, MD | ause of death (Item 23a) (Type) (1120 Neu) 2 Registrar's Signature | Hampshire | Avenue | Suite | 305, Si | Iver Spring, | | | |
| • • • | Sta Regist | ate rar | 31. Date filed (Months Pays Year) 2005 | 2 Registrar's Signature | parte | | | Maryl | and, 20904 | | | |

State of Maryland / Department of Health and Mental Hygiene 38338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Harold Vincent Connor November 08, 2005 4:40 P.M. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Egle Nursing Home Lonaconing Allegany If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 100 M 2□F Maryland 214-07-5626 Director 93 October 21, 1912 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "neturel", or Items 23a or 28e-f show other traumatic event, the Mudical Exuminar must be notified at 10d. Inside City Limits 1 XYes 2 □ No Director Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Allegany Street 21539 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "neturel", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺No þ If Yes, Give Year or Dates: Specify: Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Connor Margery Ternent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15308 Lower Georges Creek Road S.W., Frostburg, Maryland, 21532 Robert Lynn Connor-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park `4 ☐ Donation 5 ☐ Other (Specify) 11, 2005 Frostburg, Maryland 22. Name and Address of Facility. Eichhorn-McKenzie Funeal Home P.A., 8 East Main Street, 21. Signatura of Funeral Service Licenses Mickey Lonaconing, Maryland, 21539 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** er GoVasculer Walks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 No 1 Yes 2 No Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient ၉ 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation М Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Douglas Avenue, Longconing Deulin homas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 14 2005 MOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyginal 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BARBARA CASTLE NOV 2005 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dennett Rd. Manor Nursing Home 0akland Garrett If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🖾 F 578 42 5442 Jan 7, 1933 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits tems 23a or 28a-f show the Medical Examiner must be notified at Md Garrett 0akland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Mary Dr. 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2☑No ٦ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Importent: If item 27 Is marked other than 's eny injury or other treumatic event, the Me ony injury or other treumatic event, the Me ong once. Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife Homemaking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 N. 2nd St. David A. Burdock Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oakland Cemetery 11-15-05 * 4 □ Donation 5 □ Other (Specify) Oakland, MD 22. Name and Address of Facility 21. Signature of Foneral Service Licenses Burdock-Durst Oakland, MD 21 N. 2nd St. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of a Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy page 2 should be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☑ No peeq 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2□ No 1 ☐ Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 3 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42464 Nov. 14, 2005

State

Registrar

m+ Lake Park my 21751

2008 maryland Hwy

32. Registrar Signature

30. Name and address of person who completed cose of death (Item 23a) (Type, Print)

2005

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Sotiere Savopoulos

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 38340 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/06/2005 **Physician** Рм 5:30 June Virginia Colgan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Bowie Better Choice Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕅 F 10/06/1915 Director 229-66-1978 90 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene.
Important: If item 27 is marked other then "naturel; or iteme 23a or 28a-f show empty injury or other treumatic event, the Medical Examinet must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Y☐Yes 2☐No Director Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12405 Kinship Turn 20715 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home 6 Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Catherine S. Hammon William Abel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12405 Kinship Turn Bowie, MD 20715 Kathleen L. Palmer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/10/2005 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer (presumed metastatic) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ò Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has t director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physiclen: luneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assisted Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence မှ No 1 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury Certification; 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 🗌 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours of To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14999 Health Center Drive #201 Bowie, MD 20716 Kelly Tanenholz, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 8 2003

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month CUNNINGHAM Year E. November 14,2005 6.20AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death LION'S MANOR CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1731 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 169-26-3108 1 ☐ M 2 🗷 F 74 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow other traumatic event, the Medical Examiner must be notified at REDFORD HANDMAN Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral or itams Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filad within 72 hours after or Department of Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Ital 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No à Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewite own HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maczko Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Yown, State, Zip Code) BOX Hydman Thomas Conningham/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Z Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ : Joseph's cem ' 4 ☐ Donation 5 ☐ Other (Specify) timeral Home Hyndman Inter the disease co-complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part1. Approximate Interval Between Immediate Cause (Final disease of condition resulting in death) Onset and Death Physician her 3 YM /Medical Due to (g) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). physician and s the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ARDIONY OPA MI 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performe 1 Yes 2 No 2 X No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check on one) 1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death
Natural
Calcident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After ospitar .
4 hours after dea....rel Director: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier with n 24 ho To the Fune completely fi (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 5 me and address of person who completed cause of death (Item 23a) (Type, Print) on dson MD 912 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 6 2005 Registrar

unningham, Ann

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05^{Year} **Physician** Cyril Joseph Dacosta 3:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton, MD Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1(XM 2□ F 70 06-13-35 Director Trinidad, WI None Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Trinidad 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Republic of TrinidadTabago by Funeral Main Road Longdonville Chaguanas death 1 None 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpentry-Self Employed Carpenter of Health and Mental Hygitem 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorothy Ramiles Arthur Dacosta 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2923 Stinson Drive, Fort Wayne, ID 46816 Donald Solomon/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State injury or permit. Page Department o Importent: If any injury or office. 4 □ Donation 5 □ Other (Specify) Beltsville, MD Chesapeake Crematory 11-18-05 21. Signature of Funeral Septice License 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Road, Camp Springs, MD 20748 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE CORONARY SYNDROME /Medical Examiner CARDIOGENIC SHOCK securitally ist curcitors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit DNEMONIE Due to (or as a consequence of): Box 68760, attending physician AMEMIA IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Natural investigation 1 □ Yes 2 □ No within 24 hours after death.
To the Funerel Director: A 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Amil K. makazin mD. D50689 11/14/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTHERN MARYLAND HOSPITAL CENTER 7503 SYRRATTS R am nochem x CLINTON MD 20735 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygie De 0 5 tate Amend item#27,28a-f,perME,g858,8/15/06 entificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10-24-2005 6:28 p Louis Jerome Dumahaut /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2 ☐ F 368-24-8861 78 Director 09-03-1927 Michigan Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f show Washington 1 XYes 2 No Director D.C. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ the Medical Examiner must be 20010 U.S.A. 3636 16th Street, N.W. #A532 23a death Funerai 12. Was Decedent Ever in U.S. Amed Forces?

1X Yes 2 □ No 1945—
If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: Completed by 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Verizon Telephone other than Elementary/Secondary (0-12) College (1-4or 5+) Telephone Maintenance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be inent of Health and Mental 27 is marked of traumatic ever Jeannette Beattie L. Jerome Dumahaut 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 443 Parkwood Place, N.W. Washington, D.C. 20010 19a. Informant's Name/Relationship (Type, Print) nt of Health a : if item 27 is or other tra Stephanie Reich /friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment Important: it any injury o Chesapeake Crematory | 10- 28-05 Beltsville, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. Wanda ACON 3447 14th St., N.W. Wash., D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Subdural Hematoma /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examine Hospital or Attanding Physician: The law requires that the death certificate be executed physicien end the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai Se IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ò Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 385 autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death | Check only one) examiner' Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 XYes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 2 Accident 3 Suicide 1 ☐ Yes 2 No ours efter death neral Director; / filled in by the f investigation unk probable fall 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide unk within 24 hours el To the Funeral D completely filled is X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier one) 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) D 62885 10 1500 Forest Glen Road 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) FCHOS AKICHE MD Silver Spring, Maryland, 20910 Date filed (Month, Day, Year) 32. Registrar's Signature NOV 14 2005 fore Registrar

| | | 1 - For State Registrar | State of Man | yland / Dep <i>Ce</i> | artment rtificate | of Health of Deat | n and M | | ienze () eg. No. | 05 | 383 | 44 |
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| Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Mary Davis | | | | | | 2. Date of Deat Month | 9 ^{Day} | 2005 | 3. Time of 9:17 | Death A M |
| Examin | | 4a. Facility Name (If not institution, give s Atlantic General H | | | | own, or Location | on of Death | | | nty of Death cester | | |
| Funeral Director | | 213-03-0340 | M 2X F 7. Age (| In yrs. last birthday Yrs. | | Year If Und Days Hour | der 24 Hrs. s Min. | 8. Date of Birth 6/18/19 | 18 18 | 9. Birthi Cou | place (State of ntry) MD | r Foreign |
| faryland show | or | Usual Residence of Decedent | | Oc. City, Town or L | | | | | | | 10d. Inside Cit | |
| with the Nor 28a-f | Direct | 10e. Street and Number 10344 Carey Rd. | | Berlir | 10f. Zip C | | | 1 | - | of What Cou | | |
| be filed within 72 hours after death with the Maryland lied within 72 hours after death with the Maryland lately given. I have matural; or items 23a or 28a-f show a chert han "natural; or items 23a or 28a-f show a vent, the Madreal Examiner court by molified at | y Funeral Director | 11. Marital Status 1 Never Married 2 Married | 2. Was Decedent Eve Armed Forces? 1 Yes 2 XNo If Yes, Give | er in U.S. 13. | | | | ecify Yes or No- Rican, etc.) | В | lace - Americalist Americalist Americalist American Minimum Carlotte (1988) | etc. | |
| nin 72 hours n "natural", Medical Ex | Completed by | 3 XWidowed 4 Divorced 15. Decedent's Educ (Specify only highest grade | completed) | 16a, Dece (Give | edent's Usual s kind of work DO NOT use | Occupation done during m | ost of worki | ing | | Business/In | | |
| filed with Hygiene ther the | | Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) | College (1-4or 5+) | Но | memake | | ther's Name | e (First, Middle, M | | Home | | |
| y car | To Be | Ralph Shockley | - Colonia | | | E | Bettie | White | | | | |
| permit. Pages 1 and 2 should be filed within 72 ho Department of Hatilh and Mental Hygiene. Important: If Item 27 is marked other Hygiene any injury or other traumatic event, If a Medical and Proce. | | Calvin Davis (sor | 1) | 1034 | 4 Care | y Rd., | Berli | n, Md. | 21811 | | | |
| Pages 1 nent of H ant: If ite | | 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify) | | 20b. Place of Disp cemetery, cre Mitchell | matory or oth | ier place) | | | | n - City or To | | |
| permit. Departn Importe any inju | | 21. Signature of Fund I Service License | e Lao | 2 | 2. Name and | Address of Fac | cility Th | e Burbag rlin, Mo | je Fun | eral H | Home | |
| Physician /Medical | | 23a. Latt1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | e cause of each line. | e death. Do not en | | | | | | | Approximate Interval Betw Onset and D | veen |
| The law requires that the death certificate be executed at the search of the law requires that the death certificate be executed at the base been signed by the attending physician and page 2 should be detached for use as the buriat-transit | ai Examlner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (1 as a c | | 10N 4EU1 | Tus | | | | | | |
| entificate ding phys | Medical | IF FEMALE: | 20 16 | | | | | | | | | |
| that the death certificated by the attending ped by the attending pedetached for use as | Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Xho 9 Unknown | ac. If yes, outcome of particles of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the sec | Fetal death 3 | □Ectopic preg □ Other (spec | | | | | Date of delive Month | * | ear |
| v requires that been signed be should be deta | by | Part II. Other significant conditions con | tributing to death but r | not resulting in the | underlying cau | use given in Pai | rt I. | 23e. Did tob 1 ☐ Ye | _ | | he cause of de pably 4 □U | |
| The law required has been page 2 should | Completed | | | | | | | 24a. Was ar autops perform 1 Yes 2 | y | o. Were auto prior to co death? 1 ☐ Yes | psy findings a mpletion of ca 2 No | vailable use of |
| Physician: The this certificate his al director, page | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | ospital: | 2 ER/Outpatie | nt 3 DOA | Other | | n (Check only one me 5 ☐ Reside | | ther (Specif | iy) | |
| Attending Ph ar death. ector: After th by the funeral | Certification; | 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be | 28a. Date of Injury (Month, Day Y | (ear) 28b. Time (| of 280 | c. Injury at Work? 1 ☐ Yes 2 | _ | 28d. Describe ho | w injury occ | urred | | |
| To the Hospital or Attending Physician: within 24 hours after death of the Funeral Director. After this certific completely filled in by the funeral director, | | 4 Homicide determined | 28e. Place of Injury building, etc. (. | Specify) | | | U | 28f. Location (Str City or Town | , State) | | | 7 <i>01</i> , |
| To the Hospitat or within 24 hours afte To the Funeral Dir completely filted in | edical | 29a. Certifier (Check only one) 2 Medicel Examin | icien: To the best of n er: On the basis of ex and manner stated | amination and/or ir | th occurred at evestigation, in | the time, date n my opinion, d | and place, a leath occurre | and due to the ca ed at the time, da | use(s) and rate and place | nanner as st a, and due to | tated. the cause(s) | |
| To 1 To 1 | M | 29b. Signature and title of certifier ### ################################ | 4. D. | | 29c. I | D 25 | 798 | 29 | ed. Date sign | 10 ~ 0 | Day, Year) 2005 | |
| 12 | | 30. Name and address of derson who cold by the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of the Colon of t | Poleted cause of deat | h (Item 23a) (Type . D · , 310 | Print) PRA | NKLIN | AUE. | BEZL | IN, | HD | 21811 | |
| Sta Registr | ite | 31. Date filed (Month, Day, Year) NOV 1 4 70 | 32. Pagistrar's | Signature | backer | | | · . | | | | |

State of Maryland / Department of Health and Mental Hygier [] 15 For State Registra Certificate of Death 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) **Physician** 1:20 Wetzel Walter November 7, 2005 р /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 31, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number Days **Funeral** Months Hours 1⊠M 2□F Yrs. 90 Jan. 1915 Washington, 213-38-4581 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 27 Is marked other than "natural", or Iteme 23a or 28e-f ehow treumatic event, the Medical Examinar must be excitited at 1 Yes 2 No Director Maryland Kensington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 9803 Culver Street filed within 72 hours after death Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1X Yes 2 No
If Yes, Give
Year or Dates: 1941-46 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: leted by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Compl College (1-4or 5+) Elementary/Secondary (0-12) Department of Justice Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental and Mental Sarah Jane Wetzel Walter Boyd Dosh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if Health 9803 Culver Street, Kensington, MD 20895 tage () Dorothy Dosh/ Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) November 11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Gate of Heaven Cemetery permit. Page Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) 2005 Silver Spring, Marylan Francis Address Collins Funeral Home Inc 21. Signature of Funeral Service Licensee ole 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 4 Months Physician Metastatic Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit death certiticate be executed Due to (or as a consequence of) physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s prior to completion death?
1 Yes 2 No autopsy performe certificate 1 ☐ Yes 2X No : After this certification is funeral director. 25. Was case referred to medical 26. Place of Death | Check only one) Be Hospital: 1 Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Hospital or Attending 5 Pending ★ Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours atter d filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and magner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific November 9, 2005 d33293 +1 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 5454 Wisconsin Avenue, #1300, Chevy Chase, MD 20815 Frederick Smith, M.D. 31. Date filed (Month, Day, Year) 32. Degistrar's Signature NOV 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Thi November Huong Doan 10, 2005 1:35 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 200F Director 217 08 6442 88 August 5, 1917 Viet Nam Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Show r than "natural", or items 23a or 28a-f shov tre Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery **Adelphi** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 8031 New Riggs Road 20783 IISA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. fited within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fit thent of Health and Mental Hitant: If Itam 27 is marked officiary or other traumatic eventions. Be Cuu V. Doan Vy T. Nguyen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) My T. Tong / Daughter 8031 New Riggs Road Adelphi, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of He Important: If Itan any injury or oth once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 11/14/2005 Silver Spring, MD 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Swice Vicens 11800 New Hampshire Ave Silver Spring, MD 20904 Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia 10 Days **Physician** disease or condition resulting in death) /Medical Examiner Subdural Hematoma - Non Traumatic 13 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ysician and le burial-transit The law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): in to NE 10K 08 15 insion of Vital Records, P.O. Box 68760, Parkinson's Disease Physician/Medical the L attending for use as IF FEMALE 0 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autoosy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending Injury To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D54486 November 10, 2005 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 New Hampshire Avenue #310 Takoma Park, Maryland Huyanh Ton, M.D. 31. Date filed (Month, Day, Year) State NOV 14 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 5 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** NOV. 7:25 P 2005 **DaSILVA** MARIA CONCEICAO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY MARINER HEALTH NURSING HOME **BETHESDA** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛣 F Months Days Yrs. DEC. 8, 79 BRAZIL Director 220-15-9600 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show the Madical Executes must be notified at 1 XYes 2 No Director **BETHESDA** MD. MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 BRAZIL 5771 GROSVENOR LA. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes Y No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Specify: BLACK by BRAZILIAN 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC PRIVATE HOMES UNKNOWN nd 2 should be filed vilth and Mental Hygie 27 is marked other if traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be partment of Health and Menta portant: If item 27 is marked y injury or other traumatic evere. UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3917 LARO CT., FAIRFAX, VA. 22031 WILLIAM CARTER/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 1 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 11-14-2005 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A Kambur M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier DO05 36 15 NOV. 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 2005

ARUNA

NATHAN, M.D. 32. Rigistrar's Signature

11125 ROCKVILLE PIKE, SUITE 208, ROCKVILLE, MD. 20852

| | | | For State RegistraAVF7 | √#5rærTN | State (F, 11/16/05 | - | | epartme Certifica | | | | lental Hy | gien Reg. 6 | 1000 | 383 | 4.8 |
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| · 4 | | 1 | 1. Decedent's Name | | Last) | | <u> </u> | | | | | 2. Date of D | eath | | 3. Time | of Death |
| | Physici /Medio | | Grace | М. | D'As | scoli | | | | | | Novem | ber | 8, 200 | 3:10 | рМ |
| | Examir | er | 4a. Facility Name (II | | | | | 4b. City | , Town, or | Location of | of Death | | 4 | c. County of D | eath | |
| | | | | | Landing S. Sex | | yrs. last birtl | | | ville If Under | | 9 Date of Bi | | Montgo | | |
| ŀ | Funeral Director | | 5. Social Security N 214-05-7 | | 1 ☐ M 2 ☐ X F | | | rs. Months | | Hours | Min. | 8. Date of Bi (Month, D July 1 | ay, Yea | 1010 | Birthplace (State Country) | or r-oreign |
| Ġ. | σ | | Usual Residence of | J 12 | | | | | | | | July 1 | , . | 1510 | Ohio | |
| | hours after death with the Maryland tural', or items 23a or 28a-f show at Exactinat must be rediffed at | _ | 10a. State | 10b. County | | 10 | c. City, Town | or Location | | | | | | | 10d. Inside | • |
| | 8a-f. | Director | Maryland | | gomery | | Layto | nsville | | | | | | | | s 2X No |
| | with th | | 10e. Street and Nur | | | | | | p Code | | | | 10g. C | Citizen of What | Country? | |
| | eath ss 23, | Funeral | 11. Marital Status | Hawkins | Landing | | | | 882 | ispanio Ori | ain2 /Sn | nody Voc or N | | JSA | merican Indian, | |
| ' 0 | riter d | Fun | 1 Never Marri | ed 2 Marrie | Armed F | | 0.5. | If Yes, spe | ecify Cuba | n, Mexican | i, Puerto | ecify Yes or N Rican, etc.) | 0- | Black, W | | |
| 036 | ours a | ρ | 3 Widowed | 4 Divorced | If Yes, G Year or | ive | | 1 🗆 Yes | 2 No | Specify: | | | | Specify: W | hite | |
| 21215-0036 | 72 Inal | Completed | (Spec | 15. Decedent's | Education grade completed | () | | Decedent's Usu (Give kind of w | | | t of work | na | 16b. | Kind of Busine | ss/Industry | |
| 121 | d within giene. ir then " | mpl | Elementary/Seco | ndary (0-12) | College | (1-4or 5+) | | life. DO NOT i | ise retired | | | 3 | | | | |
| 22 | Hygi Hygi ther nt, 1 | | 12 17. Father's Name (| First Middle L | ast) | | | Homema | ker | 18 Mothe | r'e Name | First, Middle | | wn Home | 3 | |
| and | 0 = 0 % | o Be | Thomas d | | , | | | | | | | | | | | |
| Maryland | shoul nd Me mark | ř | 19a. Informant's Na | | | | 19b. | Mailing Addres | s (Street a | · · · · · · · · · · · · · · · · · · · | | nes Mi | | | e. Zip Code) | <u> </u> |
| | nd 2 alth a 27 is r trau | | Fred J. | D'Asco | li/ Husb | and | | | | | | | | | lle, MD | 20882 |
| J. | item item | | 20a. Method of Disp | | | | 0b. Place of | Disposition (Na | me of | | | ate | | | or Town, State | |
| Ë | Page In In It | | | ¿Cremation 3 5 ☐ Other (Spe | B □Removal from cify) | n State | /letropoí | itan Cre | natory | 7 | | mber 11 2005 | Al | exandri | a, Virg | inia |
| Baltimore, | permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 is marked any injury or other traumatic engines. | | 21. Signature of Fu | neral Service Li | censee | | | Franc | ids ^{Add} o | s of actit | lins | Funera | 1 H | lome Inc | 1. | |
| 111 | 20 E 2 3 | | 23a. Phr.1. Enter th | en Skill | 2_ | | | 500 U | nivei | sity | Blv | d, W, S | Silv | er Spr | ing, MD | 20901 |
| 8760, | Physician /Medical Examiner and the prize and the prize transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transi | icai Examiner | Immediate Cause (disease or condition resulting in death) Sequentially list confrant, leading to improve the cause. Enter Under Cause (Disease or that initiated events resulting in death) Leading to the cause (Disease or that initiated events resulting in death) Leading the cause (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the cause) (Disease or the | Final nditions, mediate rying njury | b. Aor | gestiv o (or as a co tic Va o (or as a co | nsequence o | tenosis | ure | | | | | | Interval B Onset and | |
| P.O. Box 68 | death certific e attending p id for use as | Physician/Med | IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown | months? | 4□Preg 9□ Unki | birth 2 gnant at time nown | Fetal death of death | 3⊟Ectopic p 5 □ Other (s | pecity) | | | | | 23d. Date of Month | delivery Day | Year |
| | requires that the leen signed by th hould be detache | Ď | Part II. Other signifi | | | | t resulting in | the underlying | cause give | n in Part I. | | | | _ | to the cause of | |
| ord | w requir been si should | ted | Dementia | , Usteo | arthriti | LS | | | | | | 10 | Yes : | 2 1x 1No 3 □ | Probably 4 | Unknown |
| Il Records, | The law ate has b page 2 s | Completed | | | | | | | | | | | | prior death | autopsy finding to completion of ? es 2 \(\text{No} | s available cause of |
| Vital | Physician: Th this certificate ral director, pag | Be | 25. Was case referr examiner? | | Hospital: | | | | 000 | | of Death | (Check only | one) | | | |
| ot | Phys rthis ral dia | - T | 1 Yes 25 | | 1 | | | patient 3 Do | | 7 110 | | ne 5 X Resi | | 6 Other (S | pecify) | |
| on | ding Phy th. : After this funeral c | tion | 1 ☐Natural 2 ☐ Accident | 5 Pending investiga | | of Injury nth, Day Ye | ar) In | jury | 28c. Injury Work | :?` ∕es 2 ⊟1 | | LOG. Describe | 11034 111 | ury occurred | | |
| Division | or Atten ifter deal Director: in by the | Certification: | 3 Suicide 4 Homicide | 6 Could no determin | t be 28e. Plac | e of Injury - ding, etc. (S | At home, fare pecify) | m, street, factor | | | | 28f Location (City or To | | | Rural Route Nu | mber, |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in | Medical C | 29a. Certifier (Check only one) | 1 ☐ Certifying 2 ☐ Medical Ex | Physician: To the land man | e best of my basis of exa nner stated. | knowledge, mination and | death occurred /or investigation | at the tim | e, date and pinion, deat | d place, a | and due to the ed at the time, | cause(date ar | s) and manner nd place, and c | as stated. lue to the cause | (s) |
| | To the within To the Comp | Σ | 29b. Signature and | title of certifier | | | | 29 | c. License | | | | | | onth, Day, Year) | |
|) | 18 | | 1 | oul | Cal | 1 | | | D20 | 367 | | | Nov | vember | 9, 2005 | |
| | | | 30. Name and addre | | | | | | | | | | | | | |
| | - | | Joe1 K | alman, | | 396 P | iccard | Drive, | Roc | kvill | e, M | arylan | d 20 | 0850 | | |
| | Sta Registr | - | N N | | 2005 | Registrar's | J. J. J. | goods | | | | | | | | |

| | | • | For State Registrar | State of N | /laryland | | artment | | | | | giene | 05 | 38349 |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|-------------------------------------------------------|------------------------------|-----------------------------|--------------------------------|--------------------|----------------------------|---------------------------------|------------------------------|---------------|----------------------------|----------------------------------------------------|
| | | 5 | Decedent's Name (First, Middle, I | Last) | | | | - | | | Date of Dea | th | 00 | 3. Time of Death |
| | Physici: /Medic | | Donald Sherwood | DARKIS | | | | | | No | Month ovembe | r 13, | 2005 | 5:10 P M |
| | Examin | | 4a. Facility Name (If not institution, g | give street and number | er) | | 4b. City, To | own, or | Location of | of Death | | 4c. Co | unty of Deat | h |
| | | | Ravenwood Luther | | | | Hager | | | | | | shingt | |
| | Funeral | | | . Sex 7. / 1⊠M 2□F | Age <i>(In yrs. Ii</i> 83 | ast birthday) Yrs. | If Under 1 Months | Year Days | If Under Hours | Min. | Date of Birth (Month, Day | , Year) | 9. Birt | hplace (State or Foreign untry) |
| | Director | | 217-16-2532 Usual Residence of Decedent | | 0.5 | | | | | JU | ine 10 | , 192 | Z Mai | yland |
| | /land | | 10a. State 10b. County | | 10c. City | , Town or Lo | ocation | | | | | | | 10d. Inside City Limits |
| | Mar-f st | हूं। | Maryland Washi | Ington | Ha | gerst | own | | | | | | | 1⊠Yes 2☐No |
| | or 28 |)ire | 10e. Street and Number | | | | 10f. Zip C | | | | | | of What Co | ountry? |
| | ath w | Funeral Director | 832 Kenly Avenu | | | | | | 1740 | | | USA | | days hadday |
| | items items | nue | 11. Marital Status | 12. Was Deceder Armed Force 1 X Yes 2 | s? | S. 13. | Was Deceder If Yes, specify | nt of Hi y Cuba | ispanic Ori n, Mexicar | igin? (Specify n, Puerto Ric | y Yes or No- an, etc.) | 14. | Race - Ame Black, White | |
| 36 | within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show than Adeal Examiner must be neitlisd at | by F | 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Date | s: 1943- | -46 | 1 ☐ Yes 25 | No No | Specify: | | | Sp | ecify: | white |
| 21215-0036 | 2 hou | ted | 15. Decedent's | | | 16a. Dece | dent's Usual kind of work | Occupa | ation | t of working | | 16b. Kind | of Business/ | Industry |
| 21 | ithin 7 | Completed | (Specify only highest Elementary/Secondary (0-12) | College (1-4d | or 5+) | life. | DO NOT use | retired |) | | | | c . | |
| | ygien ygien her th | | 12 | 0 | | elect | rical | eng | | tech. er's Name (F | iret Middle | airc | | |
| Maryland | permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygione. Importent: if Item 27 is marked other than "naturel; or Items 23a or 28a-f show any injury or other treumatic event, Item Musical Examiner must be notified at an once. | Be | 17. Father's Name (First, Middle, La Clarence M. Da | • | | | | | | a V. G | | Malgeri Su | mame) | |
| Ž | houtd d Me mark matic | ္ရ | 19a. Informant's Name/Relationship | | | 19b. Maili | ng Address (| Street a | | | | r. City or To | own, State, 2 | Zip Code) |
| Z | od 2 s lith an 27 is r treu | | Grace E. Darkis | | | 1 | Kenly | | | | | _ | | |
| ē, | s 1 ar f Hea ftem othal | | 20a. Method of Disposition | | 20b. P | lace of Disponent | osition (Name matory or oth | e of ner plac | e) | Date | • | 20c. Locat | ion - City or | Town, State |
| Ë | Page nent o nt: If | | 1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | (B) | | vn Cre | | | 11/14 | 1/05 | Hage | rstown | , Maryland |
| Baltimore, | permit. Departm Importe any Inju | | 21. Signature of Funeral Service Lie | censee | - | / 2 | 2. Name and | Addres | ss of Facili | ty MIN | NNICH : | FUNER | AL HOM | ſE |
| <u>m</u> | 89 = 9 | | Dat 1 | 1/10)an | mel | | | | | | | | n, Md. | 21740 |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List or | omplications that caus nly one cause on each | ed the death line. | . Do not en | ter the mode | of dyin | g, such as | cardiac or re | espiratory ari | rest, | | Approximate Interval Between Onset and Death |
| | Physician | 1 | Immediate Cause (Final disease or condition resulting in death) | _a_ PN- | eum | onic | a · | | | | | | | 7 days |
| | /Medical Examiner | | resulting in death) | Due to (or | as a consequ | ience of): | L | | | | | | | 34. |
| | ANTE | آه. | Sequentially list conditions, if any leading to immediate | b. Due to (or | as a consequ | ience of): | 1080 | 2 | • | | | | | 29ears. |
| | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | c. | | | | | | | | | | |
| o, | exec en an rial-tr | Exa | resulting in death) Last | | as a consequ | uence of): | | | | | | | | |
| 3760 | certificate be executed iding physicien and ise as the burial-transit | licai | | d | | | | | | | | | | |
| 99 x | ertific ling p | Mec | IF FEMALE: | 22a If you system | no of progna | 201 | | | | | | | , b | |
| Вох | atter for u | Physician/Med | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant | 2 Fetal | death 3 | ☐Ectopic pred | | | | | 230 | l. Date of del Month | Day Year |
| o. | 0 0 0 | ıysic | 1 □ Yes 2 □ No 9 □ Unknown | 9☐ Unknowr | | | | | | | | | | |
| α. | | by Pt | Part II. Other significant condition | s contributing to death | n but not resu | ulting in the u | ınderiying cau | use give | en in Part I | I. | 23e. Did to | bacco use | contribute to | the cause of death? |
| rds | w requires been sign should be | ed b | | | | | | | | | 1 🗆 Y | es 2□N | 10 3∏Pr | obably 4 Qunknown |
| ecords, | | Completed | | | | | | | | | 24a. Was a | an 2 | prior to | utopsy findings available completion of cause of |
| \propto | The law | Com | | | | | | | | | perfor 1 🗌 Yes | med? 2 No | death? | 2 No |
| Vital | icien: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Dth | | e of Death (C | | | | |
| of | Phys this al di | 2 | 1 ☐ Yes 2 ☑No 27. Manner of Death | I □ Inb | | ER/Outpatie 28b. Time of | | _ | | ursing Home | 5 Resid | | | city) |
| on | ding I h. After funer | tion | 1VSNatural 5 Pending 2 Accident investiga | 28a. Date of I (Month, | Day Year) | Injury | м | ic. Injun Worl | k? Yes 2□ | | | ,, | | |
| Division | Attending r death. ector: After y the fune | fica | 3 Suicide 6 Could no 4 Homicide determin | t be 28e. Place of | Injury - At ho | me, farm, st | reet, factory, | office | | 28f | Location (S | Street and N | lumber or Ri | ıral Route Number, |
| Ö | s afte | Certification; | 4 🗆 Homicide | bullaing, | etc. (Specify | ′) | | | | | Oily Or TON | ni, Siaie) | | |
| | lospital of hours are unerel D | edical | 29a. Certifier 1 Certifying (Check only 2 Medical E | Physician: To the be xaminer: On the basis | st of my kno | wledge, dea | th occurred at | t the tin | ne, date ar pinion, dea | nd place, and ath occurred | due to the dat the time, d | cause(s) an | d manner as | stated. to the cause(s) |
| | To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu | Med | 29b. Signature and title of certifier | and manner | stated. | | 29c. | License | e number | | | 29d. Date s | igned (Mont | h, Day, Year) |
| | To To con | | 10111 Sec. | 9 Mu | ap | | 200. | _ | 283 | 64 | | | 14-0 | |
| (| 73. | | 30. Name and address of son w | ho completed cause of | of death (Item | 1 23a) (Type | , Print) | | (12 | 77 V | | | | |
| 6 | +1 | | MANZAR | H2C. | AM | 368 | null | 65 | stree | eet 1 | +age, | rston | u M | D 21740 |
| | | ate | 31. Date filed (Month) Pay Year 5 | 2005 32. Ang | istrar's Signa | | sede | | | | | | | |
| | Regist | rar | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 1 | | | | | | | | |

| | | • | State State Registrar | • | artment of Health and I ctificate of Death | Mental Hygie Reg. | |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | 3. Time of Death |
| | Physicia /Medic | | Catherine Elizabeth DE | ERBYSHIRE | | | 10, 2005 12:15 a. ^M |
| | Examin | | 4a. Facility Name (If not institution, give street and | number) | 4b. City, Town, or Location of Deat | h | 4c. County of Death |
| | | | Homewood at Williamspo | | Williamsport If Under 1 Year If Under 24 Hrs | Dote of Birth | Washington |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birthday) F 88 Yrs. | Months Days Hours Min. | (Month, Day, Ye | 9. Birthplace (State or Foreign Country) 9. A swyl and |
| | Director | - | 217-10-2804 Usual Residence of Decedent | 00 | | Aug. 6, 1 | .917 Maryland |
| | /land low | | 10a. State 10b. County | 10c. City, Town or Lo | cation | | 10d. Inside City Limits |
| | Many e-f sh | tor | Maryland Washington | Willi | amsport | | 1 ☐ Yes 2X No |
| | th tha | irec | 10e. Street and Number | | 10f. Zip Code | 10g. | Citizen of What Country? |
| | death with tha Maryland ms 23e or 28e-f show rmust be nutitied at | rai | 16505 Virginia Avenue | | 21795 | | USA |
| | er dea tams | Funeral Director | Amed | d Forces? | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer | Specify Yes or No- to Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 9 | rs afte | by F | 1 Never Married 2 Married 1 X Y If Yes 3 Widowed 4 Divorced Year | es 2 \(\text{No} \), Give or Dates: 1944-46 | 1 ☐ Yes 2 ☒ No Specify: | | Specify: white |
| 2007- | tura tura | | 15. Decedent's Education | 16a, Dece | dent's Usual Occupation | 166 | b. Kind of Business/Industry |
| <u>.</u> | nin 72 | Completed | (Specify only highest grade completed | (Give life. | kind of work done during most of wo DO NOT use retired) | | |
| 7 | giene grent ar tha | mo(| 12 | | etary | | electronics company |
| and | be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Itams 23e or 28e-1 show other than "hetical Examiner must be nutilised at | Be (| 17. Father's Name (First, Middle, Last) | | | me <i>(First, Middle, Mai</i> Le Gertrude | |
| <u>ya</u> | 2 should be f and Mental H is markad of raumatic eve | မ | Hiram E. Hornbarger | 401 44 (6) | | | |
| Mar | 12 sh hand hand ism raum | 1,000 | 19a. Informant's Name/Relationship (Type, Print) William Young, JrPOA | | ng Address (Street and Number or R. Rox 1267 - 82 W | | , Hagerstown,Md.21741 |
| a) | s 1 and 2 should I Health and Mer Item 27 is marks other traumatic | 1 | 20a. Method of Disposition | | esition (Name of matory or other place) | and a state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the | c. Location - City or Town, State |
| ဋ | Pages nent of nnt: If It ury or o | | 1 X Burial 2 ☐ Cremation 3 ☐ Removal fi | rom State | | 14/05 Ha | ngerstown, Maryland |
| aitimor | | | * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | | 2. Name and Address of Facility | | UNERAL HOME |
| n | parmit. Departr Importe any inje | | 1500. ISRahi | _ 4 | 15 E.Wilson Blvd. | ., Hagersto | own, Md. 21740 |
| | Fnysician /Medical Examiner | ner | Sequentially list conditions b. | e to (or as a consequence of): | | c or respiratory arrest, | Approximate Interval Between Once; and Death |
| 8/60, | cate be executad physician and the burial-transit | dicai Examin | that initiated events c. | e to (or as a consequence of): | | | |
| O. Box 6 | The law requires that the death certific ate has been signed by the attending p page 2 should be detached for usa as | Physician/Me | in the past 12 months? | | □Ectopic pregnancy □ Other (specify) | | 23d. Date of delivery Month Day Year |
| rds, P. | quires that n signed b ald be deta | b | Part II. Other significant conditions contributing | to death but not resulting in the u | underlying cause given in Part I. | 23e. Did tobac | cco use contribute to the cause of death? 2.1000 3 Probably 4 Unknown |
| I Records, | | Completed | | | | 24a. Was an autopsy performed | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| Vital | iclen: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? Hospital: | | Out - Garage | eath (Check only one) | |
| | Jing Ph J. After th funeral | tion: To | 27. Manner of Death 1 Natural 5 Pending | 1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury Month, Day Year) 28b. Time of Injury | nt 3 DOA 4 Nursing | Home 5 Residence 28d. Describe how | ee 6 □Other (Specify) injury occurred |
| Division of | 5 # 15 E | Certification: | 3 Suicide 6 Could not be determined 28e. I | Place of Injury · At home, farm, st building, etc. (Specify) | reet, factory, office | 28f. Location (Stree City or Town, S | et and Number or Rural Route Number, State) |
| | To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the | edical C | (Check only 2 Medical Examiner: On t | o the best of my knowledge, dea the basis of examination and/or in manner stated. | th occurred at the time, date and place overstigation, in my opinion, death occurred. | e, and due to the caus curred at the time, date | se(s) and manner as stated. e and place, and due to the cause(s) |
| | To th within To th compl | Me | 29b. Signature and tuto of deriver | X | 29c. Liceose number | 29d | . Date signed (Month, Day, Year) |
| | (3) | | 30. Name and address of ers I who impleted | cause of death (Item 23a) (Type | (Print) (1) 106 |) Ho | 11/10/2001 |
| | ろ 作 / St Regist | ate rar | 31. Date filed (Month, Day, Year). NOV 15 2005 | 32. Degistrar's Signature | I WINGTON THE | | 51742 |

| | | • | For State Registrar | State of M | aryland / | | irtment o | | | | iene eg. NQ N (| 7 = | 202 | E I |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------|-------------------------|-----------------------------------------------------|------------------------------------|---------------------------|----------------------------------------|----------------------------------|-------------------------|----------------------------------------------|-----------|
| 2 J | Physici | | Decedent's Name (First, Middle, | Last) | | | | | | 2. Date of Dea Month | | J) Year | 8:54 | Death |
| | /Medic | al | 4a. Facility Name (If not institution, | COUSIS | 5) | | 4b. City, Tow | n or Location | of Doath | Novembe | r 6, 20 | | 0.54 | ам |
| | Examin | er | 1 | | 1 | | | | I DI Dealli | | | | | |
| A STATE OF | Funeral | 5 | Montgomery Gen 5. Social Security Number | 5. Sex 7. A | tal Ige (In yrs. last b | irthday) | Olne If Under 1 Ye | ar If Unde | or 24 Hrs. | 8. Date of Birth | | gome 9. Birthp | lace (State o | r Foreign |
| | Director | | 129-30-5068 | № М 2 🗆 F | 76 | Yrs. | Months Da | lys Hours | Min. | (Month, Day Aug. 6, | 1929 | Gre | | |
| | pu , | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | um or los | notice | | | | | | IOd. Inside Ci | h. Limite |
| | aryla shov | ŏ | | | | | | | | | | | 1 ☐ Yes | * |
| | the N | Directo | Maryland Montg | omery | Galt | ners | burg | ie . | | | 0g. Citizen of | What Cour | ntrv? | |
| | Sa or | <u>a</u> | 7705 Hawkins Cr | eamery Road | đ | | 208 | | | | USA | | , | |
| | be filed within 72 hours after death with the Maryland bygiene. I have then "natural", or items 23a or 28a-f show of other then "natural", or items 23a or 28a-f show event, I're Madical Exeminar must be notified at | Funeral | 11. Marital Status | 12. Was Deceden | nt Ever in U.S. | 13. V | Vas Decedent | of Hispanic O | rigin? (Spe | ecify Yes or No- | | ce - Americ | | |
| ٥ | or ite | | 1 ☐ Never Married 2 🔀 Marrie | Armed Forces od 1 Yes 25 | | | Yes, specify (| | | nican, etc.) | | ck, White, Whit | | |
| 215-0036 | ural', | d by | 3 Widowed 4 Divorced | Year or Dates | | | | | , | | | | | |
| 2 | na 'na | Completed | 15. Decedent's (Specify only highest | | 16 | (Give I | lent's Usual Oc kind of work do DO NOT use re | one durina mo | ost of worki | ing | 16b. Kind of E | lusiness/ln | dustry | |
| | filed within 72 Hygiene. other then "na' ent, Ine Modic | E C | Elementary/Secondary (0-12) | College (1-4o | r 5+) | | ractor | | | | Constri | ıctio | n | |
| 2 | filed Hygi other | | 17. Father's Name (First, Middle, L | - | | COIIC | Luctor | 18. Moth | her's Name | e (First, Middle, | | | | |
| au | should be filed within of Mental Hygiene. marked other then imatic event, the Mi | To Be | George DeKousi | s | | | | He | len F | yrpyris | | | | |
| Maryland 21 | should and Men s marke umatic | | 19a. Informant's Name/Relationsh | ip (Type, Print) | 19 | b. Mailin | g Address (Str | reet and Numi | ber or Rura | al Route Number | , City or Town | , State, Zip | Code) | |
| | and 2 ealth a n 27 is | | Ida J. DeKous | is/ Wife | 7 | 7705 | Hawkin | s Crea | mery | Road, G | aithers | burg | , MD 2 | 0882 |
| ore | of He of He or oth | l. î | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation | 3 □Removal from Stat | comet | of Dispos ery, crem | sition (Name of natory or other | f place) | Nove | mber 11 | 20c. Location | - City or To | own, State | |
| Ě | Pages ment of tant: If it jury or o | 1 | 4 □ Donation 5 □ Other (Sp | ecity) | | | iven Ceme | | | | Silver | | | |
| Baltimore, | permit. Pages 1 and 2 should Department of health and Men Important: If item 27 Is marke any injury or other traumatic once. | | 21. Signature of Funeral Service L | icensee INCPAVA | er | F2 50 | Name and Accancis O Univ | ddress of Faci J. Col ersity | lins Blvd | Funeral , W, Si | Home : lver Sp | Inc oring | , Md 2 | 0901 |
| | | | 23a. Part1. Enter the disease, or c shock, or heart failure. List of | complications that caus only one cause on each | ed the death. Do | not ente | er the mode of | dying, such a | is cardiac o | or respiratory arr | est, | - | Approximate Interval Bette Onset and I | ween |
| | Physician | | tmmediate Cause (Final disease or condition | _ a | irdian | C | Ar- | rest | | | | | Oliset and i | Death |
| | /Medical Examiner | | resulting in death) | Due to (or a | as a consequence | e of): | | • | | | | | 161 | |
| | | - | Sequentially list conditions, | b. Due to for a | | e of): | | | - | | | | 3de | remo |
| | ited insit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | Prorie | VUNUA | · 6 - | | | | | | 30 | 1.10 |
| Ć. | execuna and ial-tra | Exa | that initiated events resulting in death) Last | c. Due to (or a | as a consequence | θ of): | L | | | | | | CO | 70 |
| 8760 | sate be executed obysician and the burial-transit | dicai | | d | | | | | | | | | | |
| 9 | The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit | Med | IF FEMALE: | 1 | | - | | | | | | | | |
| Вох | leath certifica attending ph for use as th | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | | 2 Fetal deal | | Ectopic pregna | | | | | ate of delive | , | Year |
| P.O. | the a | /slci | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant 9□Unknown | at time of death | 5 🗆 | Other (specify | /) | | | | | - uy | · oui |
| | that the de ned by the a detached f | | Part II. Other significant condition | ns contributing to death | but not resulting | in the ur | nderlying cause | given in Parl | | 23e. Did to | bacco use con | tribute to t | he cause of c | leath? |
| ds, | w requires that been signed to should be deta | d by | Muelodus | plastic | Sund | | | 3 | | 1 🗆 Y | es 2 🗆 No | 3 🗆 Prot | ably 4 🛣 | Jnknown |
| COL | w request | lete | | 7,55 | | | | | | 24a. Was a | n 24b | Were auto | psy findings | available |
| Re | he lav e has ige 2 | Completed | | | | | | | | autops | med? | prior to co death? | mpletion of c | ause of |
| <u>a</u> | tician: Th certificate rector, pag | e C | 25. Was case referred to medical | | | | | 26 Plac | ce of Death | 1 ☐ Yes h (Check only or | 2 🔀 No | 1 🗆 Yes | 2 No | |
| > | ysicia s cert direct | To B | examiner? 1 ☑ Yes 2 ☐ No | Hospital: 1 Inpa | tient 2 ER/0 | Dutpatien | t 3 DOA | Other | - | me 5 Resid | | ner (Specif | fy) | |
| Division of Vital Records, | Attanding Physician: or death. ector: After this certifice by the funeral director. I | | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of Ir | njury 28b | . Time of | 28c. I | Injury at Work? | 1 | 28d. Describe h | | | ,, | |
| <u> </u> | ttandin death. ctor: Af / the fur | atic | 2 Accident investig | ation | | | | 1 Yes 2 | □No | | | | | |
| <u>≅</u> | or Attanding after death. Director: After d in by the funer | Certification; | 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi | ned 286. Place of I | Injury - At home, etc. (Specify) | farm, stre | eet, factory, off | ice | | 28f. Location (S City or Tow | | ber or Rura | al Route Num | iber. |
| | urs af | | 5/11 | | | | | | | | | | | |
| | To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page | edical | 29a. Certifier 1 Certifying (Check only one) 2 Medical 8 | Physician: To the best examiner: On the basis and manner | of examination a | ge, death and/or inv | occurred at the restigation, in r | ne time, date a my opinion, de | and place, eath occurr | and due to the c red at the time, o | ause(s) and m late and place, | anner as s and due t | itated. o the cause(s | ;) |
| | To the within 2 To the complet | Me | 29b. Signature and title of centrier | 1 | 0 | cicu | 29c. Lic | cense number | r | - 2 | 9d. Date sign | ed (Month, | Day, Year) | |
| | 10 | | () st | no Phi | eu inc | cia | 6 | 316 | 3 | | 11/6 | 105 | | |
| | 10 | | 30. Name and address of person v | who completed cause of | f death (Item 23a | (Type, | Print) | 21.0 | | | | | | |
| | | | Shyam Park | nie MO | 1810 | 01 f | rince | Phillip | o Dri | ine 101 | neu 1 | Ω c | | |
| | Sta | | 31. Date filled (Month, Day, Year) | AP. | strar's Signature | 1 | and a | | | | 1 | | | |
| | Regist | rar | NUV 0 9 | ZUUD A | esce the | A. A. | ares! | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** NOVEMBER 17TH, 16:13 2005 Laura Lee Drew /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CIMBERLAND ALLEGANY MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 M 20 F Director 215-58-6872 55 27-Jan-1950 Marvland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mental Hygiene.

Int: If Item 27 le marked other then "nature!", or Items 23a or 28a-1 ehow

Inty or other traumatic event, the Marketal Examination or untilled at 1 Yes 2 No Directo Maryland Allegany Frostburg 10e. Street and Number 11807 Old Legislative Road, S.W. 10g. Citizen of What Country? 10f. Zip Code 21532-U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) state university clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold Lee Drew Mary Hitchins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11807 Old Legislative 21532 mother Frostburg Maryland Mary Hitchins 20b. Place ORD sposition, (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 21-Nov-2005 Frostburg Maryland 4 □Donation 5 □ Other (Specify) Frostburg Memorial Park 21. Signature of Funeral Service Lig 22. Name and Address of Facility shin Durst Funeral Home, 57 Frost Ave., Frostburg, MD 215 Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive Iteact
Due to (et as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ed by the atte Day Month 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 WUnknown been signed be should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 2 No 1 Yes Division of Vital To the Hospital or Attending Physicism: : After this certifical funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ector: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Director completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and Rie of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10 D54411 completed cause of death (Item 23a) (Type, Print) M.D CALKINS, BEVERLY 500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) NOV 2 1 2005 32. Kegistrar's Signature State Registrar

| | | | For State Registrar | , | | ertificate of I | | | Reg. No. | 0.0 | 38353 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------|----------------------------------------------------|------------------------------|---------------------------------------------|---------------------------------------------|--------------------------------|------------------------------|-----------------------------|----------------------------------------------------|
| £) - | (S. 2 W | | Decedent's Name (First, Middle, La | st) | | | | 2. Date of De Month | | Year | 3. Time of Death |
| 1 4 | Physicia /Medic | | Curtis | Vance | Del | Velbiss, Sr. | | | 17 | 05 | 1414 M |
| 1 | Examin | | 4a. Facility Name (If not institution, giv | - 1 / | 101 | 4b. City, Town, or | Location of Death | / | 4c. Cou | inty of Death | 1 |
| | | < | 5. Social Security Number 6. S | ART MOSS | yrs. last birthday | Il Under 1 Year | OFRIANCI If Under 24 Hrs. | 8. Date of Bir | | le GA | |
| | Funeral Director | | | ⊠м 2□ F 91 | Yrs. | Months Days | Hours Min. | (Month, Da 06/10/ | iy, Year) | | place (State or Foreign intry) Virginia |
| - 8 | D . | | Usual Residence of Decedent 10a, State 10b, County | 100 | c. City, Town or L | ocation | | | | | 10d. Inside City Limits |
| | Maryla f eho | ō | WV Minera | | | lgeley | | | | | 1 XYes 2 No |
| | r 28a- | Director | 10e. Street and Number | | T.C. | 10f. Zip Code | | | 10g. Citizen | ol What Cou | untry? |
| | th with | | Route 1 Box 150 | ó | | 267. | 53 | | | USA | |
| | ems . | iner | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | in U.S. 13 | Was Decedent of H II Yes, specify Cuba | ispanic Origin? (Spe an, Mexican, Puerto | cify Yes or No Rican, etc.) |)- 14. F | Race - Amer Black, White | |
| 36 | filed within 72 hours after death with the Maryland Hygiene. wher than "naturel", or items 23a or 26e-f ehow ont, the Medical Examinations that the notified at | by Funerai | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | | Specify: | | | ecify: | T- 2 |
| 21215-0036 | 2 hour | ted t | 15. Decedent's E | ducation | 16a. Dec | edent's Usual Occup | ation | | 16b. Kind o | f Business/h | Mite ndustry |
| 212 | thin 7. | Completed | (Specify only highest grant Elementary/Secondary (0-12) | College (1-4or 5+) | life. | e kind of work done o DO NOT use retired | during most of workii d) | ng | | | |
| 2 | ygien ygien ygien ygien ygien | | 10 | | | Trainman | 18. Mother's Name | /Cinca & Alimania | Rail | | |
| Maryland | ntal H od ott | Be | 17. Father's Name (First, Middle, Last Larry | Riser | DaWalhi - | | | | | | , |
| Ž | should be ind Mental marked c | 은 | 19a. Informant's Name/Relationship (| | DeVelbis | ling Address (Street | Mabe1 and Number or Rura | | ena er, City or To | | ruck ip Code) |
| <u>≅</u> | and 2 s ealth ar n 27 ie | | Denise Kroll / Grand | | | rost Avenue | | | | | |
| Je, | of Hee item othe | | 20a. Method of Disposition | 29 | | oosition (Name of ematory or other place | | ate | | on - City or I | Town, State |
| Ē | Pages nent of I ant: if its ury or o | | 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci | (y) Po | | ley Mem. Gan | ١ . | 2005 | Keyse | r, West | Virginia |
| Baltimore, | permit. Pages 1 and 2 should be filed within Depentment of Health and Mental Hygiene. Important: if Item 27 ie marked other than eny injury or other traumatic event, the Magnes. | | 21. Signature of Juneral Service Lice | lelsens | | 22. Name and Addres 404 Decatur | ss of Facility Ada r Street, Cu | | 3 | | , |
| r | 87 | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | plications that caused the one cause on each line. | death. Do not e | nter the mode of dyin | ng, such as cardiac c | r respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| 1 | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. PNEUMO | ViA | | | | | | 12 /64/5 |
| | /Medical Examiner | | resulting in dealin) | Due to (or as a co | | Cn | +15 | | | | |
| 5 8 | 10 Z | er | Sequentially list conditions if any, leading to immediate cause. Enter Underlying | b. Immune Due to (or as a co | nsequence of): | w()() 3/1 | 110 | | | | |
| | cuted 1d ransit | Examiner | Cause (Disease or injury that initiated events | с. | | | | | | | |
| ő, | ificate be executed g physician and as the buriat-transit | | resulting in death) Last | Due to (or as a co | nsequence of): | | | | | | |
| 68760, | ficate to physic is the b | edicai | | d | | | | | | - | |
| Box (| - 2, 10 | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pr | | □Ectopic pregnancy | 1 | | 23d. | Date of deli | very Day Year |
| 0. | o o o | by Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at time 9□Unknown | of death 5 | Other (specify) | | | | NOTAL T | 54) |
| , P.O. | that the | y Ph | Part II. Other significant conditions | contributing to death but no | ot resulting in the | underlying cause giv | en in Part I. | 23e. Did | tobacco use o | contribute to | the cause of death? |
| rds | w requires that s been signed I s should be det | ed b | RADIATION 6 | | | | | 10 | Yes 2 □ N | 0 3 XP ro | obably 4 Unknown |
| 900 | The law requires that the ate has been signed by th page 2 should be detache | Completed | CAUCINOMA | of RECTUM | | · | | 24a. Was | an 24 | b. Were au | topsy findings available ompletion of cause of |
| = E | The law cate has I | Соп | | | | | | perf | 2 Z No | death? | 2□ No |
| Vita | ysicien: Th is certificate director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | ont 30 DOA Oth | 26. Place of Death | | | | |
| 7 | Phys r this sral dii | ٦ 1 | 1 Yes 2 SNo 27. Manner of Death | 28a. Date of Injury | 2 ER/Outpati | of 28c. Injur | y at | me 5 ☐ Res 28d. Describe | | | ufy) |
| on | Attending Physicien: or death. ector: After this certification by the funeral director, | ation | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Ye | ar) Injury | | k? Yes 2□No | | | | |
| Division of Vital Records, | | ertification: | 3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined | | | street, lactory, office | | 281. Location City or To | (Street and No wn, State) | umber or Ru | ral Route Number, |
| | e Hospital or At 24 hours after of Funeral Directetely filled in by | O | 29a. Certifier 1 1 Certifying P | hysician: To the best of m | v knowledge de | ath occurred at the fir | me date and place | and due to the | cause(s) and | I manner as | stated |
| | Fu P | edical | | miner: On the basis of exa and manner stated. | | | | | | | |
| | 2 6 2 3 | | | | | 29c. Licens | e number | | 29d. Date sig | gned (Month | Day Year) |
| | To th within To th comp | Σ | 29b. Signature and title of certifier | 1 | | | 12 0 CV | | 01 | | - |
|) | To the within Comple | 2 | 29b. Signature and title of certifier |) mell a | ふ | | 2054 | | Novem | BIL | 18, 2005 |
| | To the within comp | × | 30. Name and address of person who | completed cause of death | (Item 23a) (Typ | D 4 | | | | BIL | - |
| | To th within To th comp | × | 30. Name and address of person who | completed cause of death | (Item 23a) (Typ 912 Seton | e, Print) Drive. Cuml | | | | BIL | - |

| | | 1 - For State Registrar | State of | Marylar | | | | ealth a Death | and M | iental Hy | giene Rog. No | | 5 (| 383 | 54 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------|---------------------------|-----------------------------------------------------------------------|------------------------|--------------------------------------------------------------|-----------------------|----------------------------------|---------------------------|--------------------------------------------|--------------------|
| Physic | ian | 1. Decedent's Name (First, Middle, Last) | | | | | | | | 2. Date of De Month | ath Day | , Y | ear | 3. Time of 0 | |
| /Med | | Irene G. Evans | | | | | | | | Novemb | | | | 4:32 | P ^M |
| Exami | iner | 4a. Fecility Name (If not institution, give s Anne Arundel Medi | cal Cer | nter | | | | Annag | poli: | | | Anne | Aru | | |
| Funeral Director | | 210-22-1237 | M 20 | 7. Age (In yrs. 78 | last birthday) Yrs. | Months | Days | If Under a | Min. | 8. Date of Bir (Month, Da Aug. 1 | th ly, Year) 19 | | Countr | yland | Foreign |
| Maryland f ehow | lor | Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru | ndel | 10c. Ci | ty, Town or Lo | cation | Anr | napoli | is | | | | 100 | d. Inside City | |
| with the Isa or 28e- | Director | 10e. Street and Number 1924 Marconi Circ | ele | | | 10f. Z | p Code | 1401 | | | - | zen of Wha | | y? | |
| is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at | by Funerai | | 12. Was Deced Armed Ford 1 Tes If Yes, Give Year or Da | ces? 2.⊠No e | | Was Dec f Yes, sp 1 ☐ Yes | | ispanic Origin, Mexican | gin? (Spe i, Puerto | ecify Yes or No Rican, etc.) |)- | 14. Race - Black, Specify: | White, et | ic. | |
| within 72 houisine. | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | | 4or 5+) | | kind of w DO NOT | ork done d use retired | ation during most tment | t of work | 16b. Kind of Business/Industry Insurance | | | | | |
| uld be filed Aental Hyg rked other | To Be C | 17. Father's Name (First, Middle, Last) John Gibula | | | | | | | | e (First, Middle, eve (un | _ | _ | | | |
| and 2 short alth and h | | 19a. Informant's Name/Relationship (Type John J. Evans/sc | | | | | | | | Route Number Centre | | | | 617 | |
| Pages 1 annot of He Int. If Item | | 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) | emoval from S | itate | Place of Dispo cemetery, crer aklawn | natory or | other plac | ' 1 | | 1/2005 | | cation - Cit | • | n, State Maryla | and |
| permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any lolury or other tra | | 21. Signature of Funeral Service License | · 7 | D | 7 22 | . Name a | nd Addres | s of Facility | y Jo | hn M. T ter St. | aylo | r Fun | eral | Home | |
| Physician /Medical Examiner | | 23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | Sep Due to (c | ticemia or as a consec | a quence of): branous | | | g, such as | cardiac (| or respiratory a | rrest, | | 1 1 | Approximate nterval Betw Onset and D | reen |
| ificate be executed g physicien and as the burial-transit | dicai | that initiated events resulting in death) Last | Due to (d | or as a consec | quence of): | | | | | | | | | | |
| The Could as, T.O. Box of The law requires that the death certific ate has been signed by the ettending page 2 should be detached for use as is | hysician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 CNNo 9 □ Unknown | | nth 2 ☐ Feta antattime of d | al death 3□ | Ectopic Other (s | oregnancy pecify) | | | | | 23d. Date o Month | | | ear |
| quires that n signed b | by P | Part II. Other significant conditions con Acute renal fail | | ath but not res | sulting in the u | nderlying | cause give | en in Part I. | | | | | | cause of de | |
| VIIdi neco sician: The law re certificete hes bee rector, page 2 sho | Completed | | | | | | | | _ | 24a. Was autor perfo 1 - Yes | osy rmed? | prio | or to comp | sy findings a pletion of car No | vailable use of |
| ician ician certifi ector | Be | 25. Was case referred to medical examiner? | ospital: | | | | Oth | 20 | | Check only o | | | | | |
| ding Phys | tion: To | 27. Manner of Death XXNatural 5 Pending | 28a. Date o | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? | | | | tome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred | | | | | | | |
| To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | Certification: | 2 Accident investigation 3 Surcide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify) | | | | M 1 Yes 2 No reet, factory, office 28f. Locatio City or | | | | on (Street and Number or Rural Route Number, Town, State) | | | | | |
| e Hospita 124 hours e Funeral | edical C | 29a. Certifier 1 🏋 Certifying Phys (Check only 2 ☐ Medical Examin one) | er: On the ba | best of my kno sis of examina er stated. | owledge, deatl ation and/or in | n occurre vestigatio | d at the tim | ne, date and pinion, deal | d place, th occurr | and due to the red at the time, | cause(s) date and | and mann | er as stat d due to ti | led. he cause(s) | |
| To th within To th | × | 29b. Signature and tity of certifie | 6 1 | n | | 2 | c. License | number | | | 29d. Dat | e signed (/ | Month, Da | ay, Year) | |
| | | Muh | - the | PI | no | | 1 | D5851 | 0 | | No | vembe | er 5, | 2005 | |
| | | 30. Name and address of person who co | | | , , , , . | | bnto | e Ani | nam | lic Ma | rwal n | nd o | 1401 | | |
| S | tate | 31. Date filed (Month, Day, Year) | | egistrar's Sign | | ar C | CIICEI | - Will | iapo. | TTS, IIId | т Ата | 11U Z | 1-101 | | |
| Regis | | MOV 0 9 2005 | 200 | ne D | K (2)0 | | | | | | | | | | |

| | | 1 | For State of Ma | | ent of Health and N ate of Death | lental Hygien | | 38355 | |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------|--|
| | Physicia /Medic | an | 1. Decedent's Name (First, Middle, Last) GREGORY ANDRE | ELLIS | | 2. Date of Death Month D | ay Year | 3. Time of Death 6 10 PM | |
| | Examin | er | DITE. | 1'A EXTENDED | ity, Town, or Location of Death OWE BALT der 1 Year If Under 24 Hrs. | TIMORE 8. Date of Birth | c. County of Death | class (State or Espains | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Agr 0.65 − 40 − 83 67 1. M 2 □ F 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. Agr 7. A | 56 Yrs. | | Jan.17,19 | 949 Mar | place (State or Foreign htry) yland | |
| | yland | - | 10a. State 10b. County | 10c. City, Town or Location | | | | 10d. Inside City Limits | |
| | sa-f si | Director | aryland Calvert | | ntingtown | 10- 0 | itizen of What Cou | 1 Yes 2 No | |
| | with th | | 10e. Street and Number 6021 Stephen Reid | | Zip Code 20639 | 10g. C | USA | ind y ? | |
| 92 | s i and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. I Health and Mental Hygene. I Health and Mental Hygene. I Health and Mental Hygene. I have seen than "naturel; or Items 23e or 28e-f show other treumatic event, Ire Maulant Examiner must be notified. | 교 | 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married | Ever in U.S. 13. Was De If Yes, 9 | scedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto s 2 No Specify: | pecify Yes or No- Bican, etc.) | 14. Race - Ameri Black, White, Specify: R.1 | | |
| Ö | turel', | ed by | 15. Decedent's Education | 12/1967 16a. Decedent's L | Usual Occupation | 16b. | Kind of Business/Ir | | |
| Maryland 21215-0036 | e filed within 72 al Hygiene. I other then "na vent, ire Mauli | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) 1 1 | +) | work done during most of work Tuse retired) nance Engine | er Ho | | City uthority | |
| and | I be filed ntal Hygid ed other | Be | 17. Father's Name (First, Middle, Last) Raymond Ho | erbert | 18. Mother's Nam Edith | ne (First, Middle, Maide C.1 | en Sumame) 1 e W | | |
| aryle | 2 should be f and Mental I is marked of reumatic eve | ဥ | 19a. Informant's Name/Relationship (Type, Print) | | ress (Street and Number or Ru | | | c Code) | |
| | s 1 and 2 of Health a item 27 is other treu | | Dexter Herbert/Brother | The second second second | cephen Reid | | | | |
| Baltimore, | | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | Cemetery 11 | /9/05 Ch | Location - City or Tone Lenha | m, MD | |
| Ball | permit. Page Department of Importent: If any injury or once. | | 21. Signature of Funeral Service Licensee | 2 22. Name 1 4 5 1 | and Address of Facility S Dares Beac | ewell Fur h Rd. Pri | neral Ho Ince Fre | me d.,MD2067 | |
| The second second | Pnysician /Medical Examiner | ner | Sequentially list conditions b. | a consequence of): N — SMAL a consequence of): | F LUNG L CELL | METAS | STATIC | Approximate Interval Between Onset and Death | |
| ,820, | The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit | dical Examiner | Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as | | | | | | |
| .O. Box 6 | it the death certific by the attending p tached for use as I | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 2 ☐ Fetal death 3 ☐ Ectop | ic pregnancy (specify) | | 23d. Date of deliv Month | ery Day Year | |
| rds, P. | w requires that been signed b should be deta | by | Part II. Other significant conditions contributing to death b | ut not resulting in the underlyi | ng cause given in Part I. | 23e. Did tobacci 1 ☐ Yes | use contribute to to 2 No 3 Pro | the cause of death? | |
| Vital Records, | ysicien: The law re is certificate has ber director, page 2 sho | e Completed | 25. Was case referred to medical | | 26 Plane of Day | 24a. Was an autopsy performed: 1 Yes 2 1 | prior to co death? | opsy findings available impletion of cause of | |
| f Vii | Physicie this cert al direct | To B | examiner? 1 Tes 2 No Hospital: 1 Inpati | ent 2 ER/Outpatient 3 | 101 | ome 5 Residence | 6 □Other (Speci | fy) | |
| on of | Jing Ph | | 27. Manner of Death 1 XNatural 5 ☐ Pending (Month, Da | y Year) 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in | jury occurred | | |
| Division | To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific: completely filled in by the funeral director. | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of In building, e | ury - At home, farm, street, fa c. (Specify) | | | ocation (Street and Number or Rural Route Number, City or Town, State) | | |
| | ne Hospita n 24 hours ne Funerel | edical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st | f examination and/or investiga | | | | | |
|) | To the within To the comp | M | 29b. Signature and title of certifier She A Dash | miMD | 29c. License number 02464 | 8 11- | Date signed (Month, | Day, Year) | |
| | 5+1 | | 30. Name and address of person who completed cause of SHER A HASHMI 2 31. Date filed (Month, Day, Year) 32. Regist | death (Item 23a) (Type, Print) MD 3900 C Table Signature | D2464 OCH RAVEN | BLVD BI | 7LT 11-10X | E 21218 | |
| | Regist | ate rar | NOV 0 7 2005 | As Signature | parte | | | | |

| | | 1 | For State Registrer | State of M | aryland | / Dep | artment o | f Health and of Death | Mental Hygier | | 38356 |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------|--------------------------|----------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| | Physicia | n | 1. Decedent's Name (First, Middle, Lillian | Last) | EFR | ON | | | | Day Year 2005 | 3. Time of Death 9:00 P M |
| | /Medic Examin | | 4a. Facility Name (If not institution, Hebrew Home of | give street and number) Greater Was | ningto | n | | m, or Location of Deat ville | | 4c. County of Death Montgome | ry |
| | Funeral Director | | 100-22-6928 | 6. Sex 7. Ag 1 ☐ M 2 ☐ XF | 95 | st birthday, Yrs. | If Under 1 Y Months D | ear If Under 24 Hrs ays Hours Min. | (Month, Day, Ye | ar) 9. Birth Con 1909 New | place (State or Foreign intry) York, NY |
| | Maryland f show | | Usual Residence of Decedent 10a. State 10b. County MD Montgon | nery | | Town or L ethes | | | | | 10d. Inside City Limits 1 ☐ Yes 2X No |
| | a with the | Funeral Director | 10e. Street and Number 6701 Whittier | Blvd. | | | 10f. Zip Co | de 20817 | 10g. | Citizen of What Co. | untry? |
| 920 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If tien 27 is marked other than "natural; or terms 23a or 28a-f show any injury or other traumatic evant, the Modical Examiner must be notified at once. | Ď | 11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ XWidowed 4 ☐ Divorced | 12. Was Decedent Armed Forces' ed 1 Tyes 2 If Yes, Give Year or Dates: | ? | . 13. | Was Deceden If Yes, specify 1 ☐ Yes 2 ☐ | of Hispanic Origin? (S Cuban, Mexican, Puer No Specify: | pecify Yes or No- to Rican, etc.) | 14. Race - Amer Black, White Specify: Wh: | , etc. |
| 21215-0036 | within 72 ho ene. than "natur ne Modical | Completed | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | | 5+) | (Give life. | edent's Usual C e kind of work of DO NOT use i emaker | ccupation lone during most of wo etired) | rking | o. Kind of Business/I | ndustry |
| land 2 | 12 should be filed within " h and Mental Hygiene." 7 is marked other than " Iraumatic evant, Ira Max | To Be C | 17. Father's Name (First, Middle, I Nathan We | esterman | | | | Paulin | | in | |
| , Maryland | and 2 shou alth and N 127 is ma ar traums | . 1 | 19a. Informant's Name/Relationsh heila Taube / | nip <i>(Type, Print)</i> daughter | | | | | ural Route Number, Ci Bethesda, I | | |
| Baltimore, | Pages 1 and nont of He ant: If item ant: If item | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp | pecify) | | netery, cre | | ematory Nov | 1.11, 2005 | | dria, VA |
| Balt | permit. Departr Importa any inji | | 21. Signature of Funeral Solvice | Bylen | | | 254 Car | roll St., | rchinsky He NW, Washing | gton, DC | 20012 |
| | Physician | | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition | complications that cause only one cause on each | line. | Do not er | | b E M E | | 1 | Approximate Interval Between Onset and Death |
| | /Medical Examiner | _ | resulting in death) Sequentially list conditions, if any, leading to immediate | b. — | s a conseque | | | | | | 11-11-11-11-11-11-11-11-11-11-11-11-11- |
| ,092 | ate be executed hysician and the burial-transit | icai Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | S c | s a conseque | | | | | | |
| .O. Box 68 | ne death certific the attending p thed for use as i | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 5 No 9 ☐ Unknown | 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown | 2 Fetal | death 3 | □Ectopic preg | | | 23d. Date of del Month | ivery Day Year |
| Δ. | juires that the signed by ald be detacted | by | Part II. Other significant condition | ons contributing to death | but not resu | Iting in the | underlying cau | se given in Part I. | 23e. Did tobac 1 ☐ Yes | co use contribute to 2 No 3 □ Pr | the cause of death? |
| Division of Vital Records, | ian: The law requir rtificate has been si stor, page 2 should | Completed | | | | | | | 24a. Was an autopsy performe 1 Yes 2 | prior to | topsy findings available completion of cause of 2 No |
| Vita | sician: Th certificate irector, pag | To Be | 25. Was case referred to medica examiner? | Hospital: 1 ☐ Inpa | tient 2 🗆 E | ER/Outpati | ent 3□ DOA | Others | eath (Check only one) Home 5 Residence | e 6 Other (Spe | cify) |
| ou of | ding Phys h. After this funeral di | | 27. Marrier of Death 1 ☐ Natural 5 ☐ Pendir | 28a. Date of In (Month, E | | 28b. Time Injury | | Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how | injury occurred | |
| Divisio | To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, | Certification: | 2 Accident Investig | not be 28e. Place of I | njury - At ho etc. <i>(Specify</i> | me, farm, : | street, factory, o | office | 28f. Location (Stree City or Town, S | et and Number or Ri State) | ıral Route Number, |
| | e Hospita 24 hours e Funera letely fille | Medical C | 29a. Certifier 1 Gertifyir (Check only one) | ng Physicien: To the bes Examiner: On the basis and manner | of examinat | wledge, de ion and/or | ath occurred at investigation, in | the time, date and place my opinion, death occ | e, and due to the caus curred at the time, date | se(s) and manner as and place, and due | stated. to the cause(s) |
|) | To the within To the comp | Me | 29b. Signature and title of certifie | 'e Sur | in | M | 29c. | icense number | | Date signed (Mont | |
| | 2 | | 30. Name and address of person | who completed cause of | 6121 | 23a) (Typ | e, Print) OU (R Aparle) | OSE RI) | porle | villen | 2082005 |
| | St Regist | ate rar | 31. Date filed (Month, Day, Year, | 9 2005 32. Regi | strar's Signat | ture | Carle | / | U C | f | |

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}, **Physician** 2005 NOVEMBER 20:10P M MARY ELIZABETH CLARKE-HENSON ELDRIDGE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. MARCH 17,1897 1 □ M 2 1 F Hours MARYLAND 577-60-4550 108 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show treumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director FORT WASHINGTON PRINCE GEORGES MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 UNITED STATES or iteme 23a 12515 OLD FORT ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK À 3 XWidowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than FEDERAL GOVERNMENT 8TH GRADE ELEVATOR OPERATOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Mental LIZZIE MILES CLARKE JOHN CLARKE 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARAMINTA ANDERSON / DAUGHTER 12515 OLD FORT ROAD, FORT WASHINGTON, MARYLAND 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: if ite
eny injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GRACE U.M. CHURCH CEMETERY NOV. 17, 2005 FORT WASHINGTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) LADIA C. THORNION JOHNSON MOOS83 THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANTERIOSCIENOTIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed buriai-transit end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending physicien by Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year ŏ 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🖼 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No this i efter deeth.

I Director: After this
d in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide filled 24 hours e 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) CENTER WALDENT, Med. 12070 Q(A) gistrar's Signature State 1 0 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 05 38358 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 ea Physician November 8, 2:50 AMHelena B. Fandino /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/16/1924 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🛣 F 214-60-5996 80 Colombia Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 1802 Tufa Terrace U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or ite any Injury or other traumatic event, the Medical Examine one. 1 □ Never Married 2 □ Married Specify: Colombian Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: White Š 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Housekeeper Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carmen Fandino Ignacio Hernandez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Fandino - Son 1802 Tufa Terrace, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/13/2005 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Ignature of Puneral Service 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faillere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced transitional cell bladder cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 2 Advanced dementia 1 Yes 2 No 3 Probably 4 X Unknown been si Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No has e 2 rmed? 2**X** No certificate 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4□ Nursing Home 5□ Residence 6 MOther (Specify) Hospice ို this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending ie Hospins. n 24 hours after death. the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, MD, 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 2005 Magaza . Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11:40 A NOVEMBER 8,2005 BERNICE HOLLANDER FOSTER /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 311 S. FREDERICK AVE. GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Months Director 219-36-7625 April 24,1913 Iowa Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f shov other treumetic event, the Madical Examiner must be notified at 1XYes 2 □ No Director Gaithersburg Md. Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 5 20877 311 S. Frederick Avenue or Items 23a United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "netural", or Iter 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: Š 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anne T. Jacobson Elmer Hollander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any injury or other treun Husband 311 S. Frederick Ave., Gaithersburg, Md. Delbert T. Foster / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/14/05 Laytonsville, Md. Laytonsville Cem. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signatule of Fulheral Service Licenses M-00470 P. O. Box 5038, Laytonsville, Md. 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 3 Weeks Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Chronic atrial fibrillation, Seizure disorder, 1 Yes 2 No 3 Probably 4 Unknown Completed Remote cerebrovascular accident, Hypertension, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy Pace Maker 2X No 1 ☐ Yes 2 ☐ No Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Cutpatient 3 DOA 2 1 🗌 Yes 2**⊠** No this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: . After t 5 Pending investigation 1 🗷 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 November 8, 2005 D-04115 14. Riberthi 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 201 Russell Ave., Gaithersburg, Md. H. Robert Birschbach, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOA 10 2005 Registrar A BARLE

| | | | 4 101 | artment of Health and Mental H | ygiene Reg. No. 05 38360 | | | | | | | |
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| | | | Decedent's Name (First, Middle, Last) | 2. Date of D | | | | | | | | |
| | Physicia | | Patricia Denton Freeland | Month Novem | ber 3, 2005 1:15 P. M | | | | | | | |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | | | | | | | |
| | | eı | 115 Allnutt Court, Apt. #610 | Prince Frederick | Calvert | | | | | | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24 Hrs. 8, Date of E | Birth 9 Birthplace (State or Foreign | | | | | | | |
| | Director | | 216–34–1268 ^{1□ M 2} XF 67 Yrs. | Months Days Hours Min. (Month, I | 21, 1937 Maryland | | | | | | | |
| | D | | Usual Residence of Decedent | | | | | | | | | |
| | nylan how | | 10a. State 10b. County 10c. City, Town or L | ocation | 10d. Inside City Limits | | | | | | | |
| | a-fs | cto | Maryland Calvert Prince Fre | ederick | 1 ☐ Yes 2 🛣 No | | | | | | | |
| | th th or 28 |)ire | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? | | | | | | | |
| | 23a | a | 115 Allnutt Court, Apt. #610 | 20678 | United States | | | | | | | |
| | r dea | Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) | No- 14. Race - American Indian, Black, White, etc. | | | | | | | |
| 36 | 72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exemple: nust be publified at | ΥF | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give | 1 ☐ Yes 2X No Specify: | Specify | | | | | | | |
| ë | ural', | d by | 3 Wildowed 4 Divorced Year or Dates: | | White | | | | | | | |
| 7 | "nat | Completed | (Specify only highest grade completed) (Give | dent's Usual Occupation with the kind of work done during most of working DO NDT use retired) | 16b. Kind of Business/Industry | | | | | | | |
| 12 | within ane. than | m d | Elementary/Secondary (0-12) College (1-4or 5+) Cleri | ŕ | Maryland State | | | | | | | |
| 2 | Hygid Hygid ther int, | | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Midd. | Government | | | | | | | |
| an | ad be | Be c | Wilson Edward Denton | Etta Lorena Je | | | | | | | | |
| 2 | hould Me mark matte | 2 | | ing Address (Street and Number or Rural Route Num | | | | | | | | |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examined into the Legisland and pones. | | | Cerrace Drive, Prince Fr | | | | | | | | |
| ģ | 1 an Heal tem 2 | | 20a. Method of Disposition 20b. Place of Dispo | osition (Name of Date | 20c. Location - City or Town, State | | | | | | | |
| Baltimore, | ages nt of t: If It | | W☐ Burial 2 ☐ Cremation 3 ☐ Removal from State | matory or other place) | | | | | | | | |
| ₽ | it. Puritme | | | Island Cemetery 11/7/05 2. Name and Address of Facility Rausch F | | | | | | | | |
| Ba | permi Depa Impo any is | | 1 / / / / / / / / / / / / / / / / / / / | 1405 Broomes Island Rd., Port I | 112° • | | | | | | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not en | | 0.00 | | | | | | | |
| В | | | shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Pnysician /Medical | i IV | resulting in death) | CARIBIOVA | FEW | | | | | | | |
| | Examiner | | Due to (or as a consequence of): $0.1 \le A \le C$ | | HOURS | | | | | | | |
| | | - | Sequentially list conditions, if any, legating to first adiate. Due to (or as a consequence of): | | | | | | | | | |
| | ted | nin | cause. Enter Underlying Cause (Disease or injury | | | | | | | | | |
| | xecu and al-tra | Examiner | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| 8760, | icate be executed physician and s the burial-transit | | | | | | | | | | | |
| 687 | icate phys s the | hysician/Medical | d. | | | | | | | | | |
| | death certifics e attending ph d for use as t | W/W | IF FEMALE: 23c. If yes, outcome of pregnancy | | 23d. Date of delivery | | | | | | | |
| Вох | atter for u | ciar | in the past 12 months? | □Ectopic pregnancy □ Other (specify) | Month Day Year | | | | | | | |
| o. | 0 0 | ıysi | 1 Yes 2 No 9 Unknown | | | | | | | | | |
| <u>α</u> | requires that the een signed by th hould be detache | ۵. | Part II. Other significant conditions contributing to death but not resulting in the u | underlying cause given in Part I. 23e. Did | tobacco use contribute to the cause of death? | | | | | | | |
| gp | uires sigr ld be | d by | Typerlansin | 1 | Yes 2 No 3 Probably 4 Urknown | | | | | | | |
| 201 | > 0 0 | lete | | 24a. Wa | s an 24b. Were autopsy findings available | | | | | | | |
| Re | e la has je 2 | ompleted | | aut | opsy prior to completion of cause of death? | | | | | | | |
| = | | e Co | DE Was asso referred to madical | 1 ☐ Yes | | | | | | | | |
| C | @ = U | B | 25. Was case referred a medical examiner? Hospital: | 26. Place of Death (Check only | | | | | | | | |
| Vita | cer rec | 0 | 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient | nt 3□ DOA Other: 4□ Nursing Home 5 R | ence 6 ☐Other (Specify) | | | | | | | |
| of Vital Records, | Phys this ral dii | 2 | 27. Manney of Death 28a, Date of Injury 28b, Time of | of 28c Injury at 28d Describe | how injury occurred | | | | | | | |
| of | ding Phys h. After this funeral di | \vdash | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 New Stination | Work? | how injury occurred | | | | | | | |
| of | ding Phys h. After this funeral di | \vdash | 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st | Work? M 1 ☐ Yes 2 ☐ No | | | | | | | | |
| of | ding Phys h. After this funeral di | ertification; T | 1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation | Work? M 1 □ Yes 2 □ No reet, factory, office 28f. Location | Street and Number or Rural Route Number, | | | | | | | |
| Division of Vita | ding Phys h. After this funeral di | Certification; T | 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, st. building, etc. (Specify) | Work? M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Location City or To | (Street and Number or Rural Route Number, own, State) | | | | | | | |
| of | Hospital or Attending Phys 4 hours efter death. Funeral Director: After this ely filled in by the funeral di | Certification; T | 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, st. building, etc. (Specify) | Work? M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Location City or To | (Street and Number or Rural Route Number, own, State) | | | | | | | |
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| of | or Attending Physiter death. Director: After this in by the funeral dir | edical Certification; T | 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Cerifier (Check only one) 1 Acertifying Physicien: To the best of my knowledge, deat and manner stated. (Month, Day Year) 1 Nigry (Month, Day Year) 28e. Place of Injury - At home, farm, st building, etc. (Specify) | Work? M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Location City or To th occurred at the time, date and place, and due to the ivestigation, in my opinion, death occurred at the time | (Street and Number or Rural Route Number, own, State) e cause(s) and manner as stated. e, date and place, and due to the cause(s) | | | | | | | |
| of | Hospital or Attending Phys 4 hours efter death. Funeral Director: After this ely filled in by the funeral di | edical Certification; T | 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier Accident 5 Pending investigation 28e. Place of Injury - At home, farm, st building, etc. (Specify) 28e. Place of Injury - At home, farm, st building, etc. (Specify) 28e. Place of Injury - At home, farm, st building, etc. (Specify) 28e. Place of Injury - At home, farm, st building, etc. (Specify) 28e. Place of Injury - At home, farm, st building, etc. (Specify) 28e. Place of Injury - At home, farm, st building, etc. (Specify) 29b. Signature and title of certifier Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accident Accide | work? M 1 □ Yes 2 □ No reet, factory, office 28f. Location City or To th occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time 29c. License number 194 & 7 | (Street and Number or Rural Route Number, own, State) e cause(s) and manner as stated. b, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) | | | | | | | |
| of | Hospital or Attending Phys 4 hours efter death. Funeral Director: After this ely filled in by the funeral di | edical Certification; T | 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, | work? M 1 □ Yes 2 □ No reet, factory, office 28f. Location City or To th occurred at the time, date and place, and due to the ivestigation, in my opinion, death occurred at the time 29c. License number 194 27 Print) | e cause(s) and manner as stated. b, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) | | | | | | | |
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| | | | 1 - For State Registrar | State of Maryla | nd / Dep | artment of h | lealth and M Death | lental Hyg | iene 20 0 5 | 3836 I |
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| | Physici | an | 1. Decedent's Name (First, Middle, Last | | | | | 2. Date of Deat Month | • • | 3. Time of Death |
| | /Media | al | | eixo Figue | eira | 45 City Taylor | all and a st Darett | Nov. 11 | | 10:48a M |
| | Examir | ier | 4a. Facility Name (If not institution, give Prince George 5. Social Security Number 6. Se | s Medical (| Center | Chev | erly If Under 24 Hrs. | 8 Date of Righ | | George's |
| | Funeral Director | | | DM 2□F 70 | Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, Jan. 23 | , 1935 GO | thplace (State or Foreign ountry) a, India |
| | Maryland | tor | MD 10a. State 10b. County Montgom | | ity.Town or L ilver | Spring | | | | 10d. Inside City Limits 1 ☐ Yes ₹☐ No |
| | th with the 23a or 28 | Funeral Director | 10e. Street and Number 3911 Ilford Roa | ıd | | 10f. Zip Code 2090 | 6 | 10 | 0g. Citizen of What C USA | ountry? |
| 980 | ermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene. Inportant: If item 27 is marked other then "neturel", or Items 23a or 28e-f show myorrant: If item 27 is marked other then "neturel", or Items 23a or 28e-f show my injury or other freumetic event; Ite Mudical Extraction of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of the Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of Indifficult of I | by Funer | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | U.S. 13. | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No | lispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Ami Black, Whi Specify: | |
| Baltimore, Maryland 21215-0036 | within 72 ho ane. Ithen "netu | Completed | 15. Decedent's Edi (Specify only highest grad | ucation de completed) College (1-4or 5+) | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most of work d) | ing | 16b. Kind of Business Photogra | |
| ld 2 | illed Hygie other | Be Co | 12 17. Father's Name (First, Middle, Last) | | 1 110 | co grap | 18. Mother's Name | | | F7 |
| /lar | Menta Menta arked | To B | Manuel Figueira | a . | | | | Ann Fig | gueira | |
| , Mar | and 2 sho salth and n 27 is mu er treume | | 19a. Informant's Name/Relationship (T) Virginia Figuei | * * * * * * * * * * * * * * * * * * * * | 19b. Maili 39 | ng Address <i>(Str</i> eet 11 Ilfor | and Number or Run d Road | al Route Number, Silver | City or Town, State, Spring, M | Zip Code) Id 20906 |
| more | Pages 1. | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, | Removal from State | cemetery, cre | osition (Name of matory or other place f Heaver | ce) | | Silver S | Town, State Spring, Md |
| Balti | permit. Departn Importe any inju | | 21. Signature of uneral Service Lice | under | | | | | AL SERVIC | CE, P.A. ng, Md20910 |
| | | | 23a. Part1. Enter the disease, or comp shock, or heary failure. List only of | lications that caused the decone cause on each line. | | | | | | Approximate Interval Between Onset and Death |
| | Pnysician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a Myocardi Due to (or as a conse | | ilure | | | | 45mo |
| р | Examiner | | Sequentially list conditions. | _{b.} Coronary | Arte | ry Disea | se | | | 4mo. |
| | cuted nd ransit | Examiner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consect. Diabetis | | itis Ins | sulin de | pendent | | 20 yrs |
| 8760, | icate be executed physician and s the burial-transit | icai Ex | resulting in death) Last | Due to (or as a conse | equence of): | | | | | |
| P.O. Box 68 | The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of preg 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fe}\) 4 \(\subseteq \text{Pregnant at time of}\) 9 \(\subseteq \text{Unknown}\) | tal death 3 | □Ectopic pregnancy □ Other (specify) | / | | 23d. Date of de Month | livery Day Year |
| | quires that to n signed by uld be deta | by | Part II. Other significant conditions correspond to the remail failure | - | _ | | en in Part I. | | acco use contribute to | o the cause of death? |
| I Records, | | Completed | sepsis | | | • | | 24a. Was ar autopsy perform 1 \sum Yes 2 | v prior to | utopsy findings available completion of cause of |
| Vital | Physicien: T r this certificat ral director, pi | Be | 25. Was case referred to medical examiner? | Hospital: | | Oth | 26. Place of Deati | (Check only one | 9) | |
| on of | ling Phys I. After this funeral dir | tion; To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | of 28c. Injur Wor | 4 Li Nursing no | me 5 Reside 28d. Describe ho | nce 6 Other (Spe w injury occurred | cify) |
| Division of | of or Attending after death. I Director: After d in by the fune | ertification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At building, etc. (Spec | home, farm, st | | | 28f. Location (Str City or Town | reet and Number or Ri State) | ural Route Number, |
| | To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by | edicai C | 29a. Certifier 1 Certifying Phy (Check only one) | ysician: To the best of my killiner: On the basis of examinand manner stated. | nowledge, deat nation and/or in | h occurred at the tire | me, date and place, pinion, death occurr | and due to the ca red at the time, da | use(s) and manner as ite and place, and due | s stated. to the cause(s) |
|) | To th withir To th comp | Me | 29b. Signature and little of certifier | engy | | 29c. Licens | 2 7 3 | MD 25 | Od. Date signed (Mont | h, Day, Year) |
| • | 3 | | 30. Name and address of person who c | | | | | | · . ! | |
| | Sta | te | Revathymur MI 31. Date filed (Month, Day, Year) | 32 Pegistrar's Sign | nature | | andover | ,Maryla | nd | |
| | Registi | ar | NUV 14 20 | 005 America | K A | 240 | | | | |

| | | | State of Maryland / Department of I State of Maryland / Department of I Certificate of | | Mental Hygie | ZUUS . | 38362 |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------|-------------------------------|----------------------------------------------------|
| ۰ | | | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death | | 3. Time of Death |
| | Physicia /Medic | | PAUL CLIFFORD FLICK | | NOVEMBER | 13 2005 | 1:28 P M |
| , | Examin | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, | or Location of Death | | 4c. County of Death | |
| | | ٠ | | ONSBORO | | WASHI | |
| | Funeral Director | | 5. Social Security Number 225-18-5111 6. Sex 1 Months 1 Months 2 F 84 1 Months 1 Months 1 Months 2 F 84 1 Months 1 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Months 2 Month | | 8. Date of Birth (Month, Day, Ye DEC. 13, | | place (State or Foreign ntry) RGINIA |
| | | | Usual Residence of Decedent | | 1020. 20, | | |
| ırylar | d at | _ | 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits |
| e Me | 89-1 e | Director | | ONSBORO | | | 1 ☐ Yes 2 🔯 No |
| Aj. | Le n | a | 10e. Street and Number 10f. Zip Code | 04 = 4 0 | 10g. | Citizen of What Cou | , |
| aath v | s 23e | ral | 8507 MAPLEVILLE ROAD 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of | 21713 | and the Young his | U.S.A | |
| ter de | Item | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No 1942− 1 ☑ Yes | ban, Mexican, Puerto | Rican, etc.) | Black, White, | |
| G Z1Z15-UU36 filed within 72 hours after death with the Maryland | ital Hygiene. id other then "neturel", or Items 23a or 28e-1 ehow event. The Medical Examinst must by multified at | þ | 3 X Widowed 4 □ Divorced If Yes, Give 1945 1 □ Yes 2 No | Specify: | | Specify: | WHITE |
| 2 2 2 5 | netur | Completed | 15. Decedent's Education 16a. Decedent's Usual Occu (Specify only highest grade completed) (Give kind of work done | upation e during most of work | kina 16t | o. Kind of Business/Ir | ndustry |
| ig V | en. | Jqr. | Elementary/Secondary (0-12) College (1-4or 5+) | ed) | | ATTEC BODIE | GTTO D |
| 1 % pe | Hygier ther ti | | 6 COLLISION | N REPAIRMA | ine (First, Middle, Mai | AUTO BODY | SHOP |
| 2 3 | d o d | Be | | | RANCES JO | | |
| aryle should | nd Menta marked matic ev | 은 | JOHN HENRY FLICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree | | | | c Code) |
| ž ž | 2 st 2 | | CYNTHIA LIDA/DAUGHTER P.O. BOX 8, | | | | , |
| s tar | f Hea item othe | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date 200 | . Location - City or T | own, State |
| altimore, mit. Pages 1 a | nt: If it | | 1 🛣 Burial 2 □ Cremation 3 🖾 Removal from State '4 □ Donation 5 □ Other (Specify) PANORAMA MEM. GAR | 1 | 6/2005 WA | TERLICK V | TRGTNTA |
| Balti permit. | | | 21. Signature of Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental Fundamental F | ress of Facility | | National 1 | |
| n 8 | 2 = 2 | | kelly A. Zimmerman BAST FUNER | RAL HOME | | , Maryland | |
| | | | 23a. Raft1. oner the disease of complications that caused the death. Do not enter the mode of dy shock, deheart failure. List only one cause on each line. | ring, such as cardiac | or respiratory arrest, | | Approximate Interval Between Onset and Death |
| | iysician | | Immediate Cause (Final disease or condition a. atheroschute H | east & | disease | - | Onset and Death |
| | Medical xaminer | | resulting in death) Due to (or as a cons + uence of): | | | | |
| | | e | Sequentially list conditions, Due to jor as a consequence of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the | | | | |
| ted | nsit | ulu u | cause. Enter Underlying Cause (Disease or injury | . O D. | - 44 | | |
|), execu | n and al-tra | Examin | that initiated events resulting in death) Last c. Due to (or as a consequence of): | - ese | an | | |
| 8/6U, cate be executed | physician and the burial-transit | dlcal | d | | | | |
| | | Medi | IF SEMALS. | | | | |
| . Box to death certifi | attending p | an/h | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy | су | | 23d. Date of deliv | ery Day Year |
| De dea | 0 0 | Physiclan/Me | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _ 9 ☐ Unknown | | | MONIT | Day |
| Hecords, P.O. | ed by the a | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi | iven in Part I | 23e, Did tobac | co use contribute to t | he cause of death? |
| dS, lires t | signe d be d | d by | Dimente | | | 2 □No 3 □ Prol | |
| | been si should | ete | 7 | | 24a. Was an | 24h Were autr | ppsy findings available |
| VITAL RECOLDS sicien: The law requires | e has | Completed | | | autopsy performed | prior to co | mpletion of cause of |
| | | Ö | 25. Was case referred to medical | 26 Place of Dea | 1 ☐ Yes 2 ☑ th (Check only one) | No 1 □ Yes | 2 No |
| /sicie | s cert direct | 0 8 | examiner? | 46.00 | ome 5 Residence | e 6 ⊡Other (Specia | (v) |
| Of Of Phy | n. After this certificate has funeral director, page 2 | T:u | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury Wo | | 28d. Describe how i | | ,, |
| SIO! | or: Af | atlc | 2 Accident investigation M 1 |]Yes 2 □No | | | |
| DIVISION I or Attending | irecte irecte n by t | Certification; | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | Э | 28f. Location (Stree City or Town, S | t and Number or Rura tate) | al Route Number, |
| pitel c | eral D | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the t | time, data and place | and due to the save | a/a) and magaar as a | tatad |
| DIVISION OF VITA To the Hospitel or Attending Physicien: | within 24 hours after death. To the Funeral Director: A completely filled in by the fr | edical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated. | | | | |
| To th | within To th comp | Me | 29b. Signature and title of certifier 29c Licen | nse number | 29d. | Date sighed (Month, | Day, Year) |
| a | B. Q | | Vincent A Canto mp De | 00503 | 62 | 11/14/00 | 5 |
| | 73.5 | 1 4 | | | | 1. 1 | |
| 6 | 5+111 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | |
| 6 | Sta | | Vincent A. Cantone, M.D. 22911 Jefferson VI 31. Date filed (Month, Day, Year) 32. Registrar's Signature | lfd., Smit | hsburg, M | D 21783 | |

| n | 1. Decedent's Name (F | | | | | | | | | | 2. Date of I Month | Day | | Year | 3. Time |
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| al er | 4a. Facility Name (If no | | | and numb | er) | | 4b, City. | Town, or | Location | of Death | Nov | 10 4c. | | 2005 ty of Death | 2:1 |
| 28 | Genesis H | | | | , | Pines | | | ston | | | | | albo | |
| | 5. Social Security Number 216-40-433 | | 6. Sex 1 ☐ M 2 | X F 7. | Age (in y | rs. last birthda Yrs. | Months | | If Under Hours | 24 Hrs. Min. | 8. Date of E | 3, Y13/ | 41 | | nplace (State |
| | Usual Residence of De 10a. State 10 | b. County | | | 10c. | City, Town or | Location | | | | | | | | 10d. Inside |
| ত্ | MD | T | ALBOT | | | EA | STON | | | | | | | | 1 📇 Y |
| Director | 10e. Street and Number | ər | | | | | 10f. Zip | Code | | | | 10g, Citi | zen of | f What Cou | untry? |
| aiD | 610 DUTCI | RIVANE | LANE | | | | | | 601 | | | | | USA | <u> </u> |
| by Funeral | 11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 | | ied 1 [| as Decede med Force Yes 2 Yes, Give ear or Date | S? XNo | n U.S. 13 | 3. Was Deced If Yes, spec | | | | ecify Yes or I Rican, etc.) | No- | | ack, White | ncan Indian, e, etc. VHITE |
| Completed | 15 (Specify | . Decedent | t's Education | pieted) | | (Gi | cedent's Usua ve kind of wo | irk doné a | turina mos | t of work | ring | 16b. Kii | nd of I | Business/li | Industry |
| mp | Elementary/Seconda | ary (0-12) | Co | ollege (1-4 | or 5+) | | . DO NOT u: ITTER | se retired, |) | | | HON | (12 1 | upat T | H CAR |
| ပို | 17. Father's Name (Fire | st, Middle, | Last) | <u> </u> | | <u> </u> | LIIGK | Т | 18. Mothe | ər's Nam | e (First, Mida | | | | II CAK |
| Ö | ROY WHIT | ľBY | | | | | | | OLI | IE V | VILLIAN | 1SON | | | |
| _ | 19a. Informant's Name | | | - | | | • | | | | al Route Nun | | | | |
| | BARBARA I | | GAN/SIS | STER | 20 | b. Place of Dis | | | CREEK | | PRES | _ | | | |
| | 20a. Method of Dispos | Cremation | | al from Sta | ate | cemetery, c | rematory or o | other place | | | | | | | Town, State |
| | * 4 □ Donation 5 [21. Signature of Funer | | | | G | REENMO | UNT CE 22. Name an | | | | 4-2005 | HII | LLS | BORO, | MARY |
| | 21. Signature of runer | | RCE | o ~ ` | | | FELLOW | S, H | ELFEN | BEIN | & NEV | | | | HOME |
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| sal Examiner | Immediate Cause (Findisease or condition | ailure. List aal tions, adiate ng ury | a | Due to (or | as a con | pirati | enter the mod | de of dying | g, such as | cardiac | | arrest, | | | Interval B |
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What we will be a second of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co | d tobacco u Yes 2 as an topsy rformed? Sidence 6 how injury own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and own, State, and o | 23d. D M M See cor No 24b. 35 Ott y occu and mumi | Date of delike from the following the following to condeath? I yes ther (Special following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following following foll | Nerry Day the cause of bably 4 topsy finding completion of 2 No ral Route No. stated. to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the |

| | | | 1 - For State Registrar | State of N | narylan | | | nt of H te of L | | | ental | Hygier Reg. i | 2 U U | 5 | 38364 |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------|---------------------------------|------------------------|-----------------------------|-----------------------------------|-----------------------------------|--------------------------|---------------------------------|----------------------------|------------------------|----------------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle, L DOD DDD DDD DDD DDDD | | | | | | | | 2. Date of Month | | Day | Year | 3. Time of Death |
| | /Medic Examin | | ROBERT PAUI 4a. Facility Name (If not institution, g | | | | 4b. City | , Town, or | Location | | JOVEM | | 7, 20 4c. County | 005 of Death | 6:45 A [™] |
| | ZAGIIII | | MEMORIAL HOSP | ITAL | | | C | UMBER | LAND |) | | | _ | EGAN | |
| | Funeral | | Social Security Number 6. | | ige (In yrs. I | last birthday) | If Unde | or 1 Year Days | If Unde Hours | r 24 Hrs. Min, | 8. Date of | of Birth | ar) | 9. Birth | place (State or Foreign intry) |
| | Director | | 234–42–9714 Usuel Residence of Decedent | 1 X M 2□ F | 75 | Yrs. | | | | | | 25, 1 | | | NNSYLVANIA |
| | iand ow | | 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | | | | 10d. Inside City Limits |
| | Mary Ff sh | tor | WV MINE | CRAL | R | IDGEL | ΕY | | | | | | | | 1 ☐ Yes ¾ ☐ No |
| | th the | lrec | 10e. Street and Number | | | | | ip Code | | | | 10g. (| Citizen of V | Vhat Cou | intry? |
| | 23a d | raic | ROUTE 1, BOX | 496 | | | | 2675 | 3 | | | | U.S. | Α. | |
| 36 | should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "natural", or Items 23a or 28s-f show unatic event, tra Madical Examirer must be rotilised at | by Funeral Director | 11. Marital Status 1 □ Never Married XIXMarried | 12. Was Deceder Armed Forces 1 ☐ Yes 2 X If Yes, Give | i?] No | 1 | _ | edent of His ecify Cubar | spanic O. n, Mexica Specify | rigin? (Spe in, Puerto f /: | cify Yes o Rican, etc | r No- .) | | k, White | |
| Maryland 21215-0036 | tural | ed b | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's | Year or Dates | : | 16a. Deced | ent's Hs | ial Occupa | ition | | | 16h | Kind of Bu | WI | HITE |
| 212 | nin 72 | Completed | (Specify only highest g | rade completed) College (1-40) | 5.1 | (Give | kind of w | ork done d use retired) | luring mo: | st of workir | ng | 100. | . Killid Of Bo | 13111033/11 | loustry |
| 2 | filed witl Hygiene other the | Som | 12 | College (1-40) | 3+) | MA | CHI | VIST | | | | | RAI | LRO | AD |
| 2 | be file d oth event | Be | 17. Father's Name (First, Middle, Las | | | | | | | er's Name | | ddle, Maid | en Sumam | Θ) | |
| <u>\S</u> | should ind Men marke umatic | ၉ | ROBERT MARSH | | HER | 1 121 11 11 | | | | LDRE | | FRED | | AYNI | |
| <u>ā</u> | C 4 - 2 | i l | 19a. Informant's Name/Relationship | | urnn | 19b. Mailin | | | | 496, | | | | | |
| <u>Б</u> | ges 1 and of Health if item 27 or other tr | | MARTHA DORIS F 20a. Method of Disposition | ISHER / | | lace of Dispos | sition (Na | me of | | | ate IX II I | | Location - | | 26753 own, State |
| altimore, | Pages nent of int: if it iry or o | | tXXSurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | □Removal from Stat ify) | 9 | emetery, crem SET MEI | - | | · . | 11/10 | /200 | 5 (| CHMB | ERLZ | AND, MD |
| <u>=</u> | permit. Page Department Important: if any njury or once. | | 21. Signature of Funeral Service Lic | odsod | , | | Name a | nd Address | s of Facil | lity | | | | DICE | 111, 111, |
| <u> </u> | 80E # 9 | | Thereof P. | Uprhu | | | 202 | GREE | NE S | ÉRAL TREET | CU | MBERL | AND, | MD. | 21502 |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | nplications that cause y one cause on each | ed the death line. | n. Do not ente | er the mo | de of dying | g, such as | s cardiac of | respirato | ry arrest, | | | Approximate Interval Between Onset and Death |
| , | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | | | PLEURAI | _EFI | TUSIO | N | | | | | 2 | WEEKS |
| | Examiner | | | Due to (or a | | uence of): PNEUM | אדד א | | | | | | | | DAYS |
| | ζ. | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or a | | | JIVIA | | | | | | | Z | DAIS |
| | ificate be executed g physician and as the burial-transit | Examiner | Cause (Disease or injury that initiated events | C | | LIGNANC | CY | | | | | | | 3 | WEEKS |
| 90 | oe execian a | | resulting in death) Last | Due to (or a | s a consequ | ience of): | | | | | | | | | |
| 68760, | icate l physi s the b | edical | | d | | | <u> </u> | | | | | | | | |
| Box | | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | | | | | | | | 23d. Date | e of deliv | erv |
| o. | requires that the death cer een signed by the attendin hould be detached for use | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown | | | Ectopic p Other (s | pecify) | | | | _ | Mor | | Day Year |
| S, | ss that gned t | by P | Part II. Other significant conditions | contributin g to death | but not resu | ıltin g in the un | derlying | cause give | n in Part | l. | 239. [| Oid tobacco | o use contr | ibute to t | he cause of death? |
| Vital Records, | w requires to been signer should be | ted | ASBESTOSIS | | | | | | | | 1 | Yes | 2 No | 3 🗌 Prol | oably 4 □Unknown |
| ပ္တ | | Completed by | | | | | | | | | | Vas an utopsy | 24b. V | Vere auto | ppsy findings available impletion of cause of |
| <u> </u> | : The cate ha | So | | | | | | | | | 1 🗆 Y | erformed? es 2 1/2 11 | d d | eath? | 2□ No |
| Ž | Physician: The law r this certificate has I ral director, page 2 s | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Other | | e of Death | | - | | _ | |
| Ö | Phy this | 5.7 | 1 ☐ Yes 2 ☑ No 27. Manner of Death | 28a. Date of In | urv | ER/Outpatient 28b. Time of | | OA 28c. Injury Work | 4 🗀 141 | ursin g Hom | | | 6 Othe | | (y) |
| <u></u> | Attending I r death. ector: After by the funer | atio | 1 Natural 5 ☐ Pending 2 ☐ Accident investigati | (Month, D | ay Year) | Injury | м | | ? ′es 2. □ | | | | | | |
| Division of | i i i i e | Certification; | 3 ☐ Suicide 6 ☐ Could not determine | 256. Place of It | njury - At ho tc. (Specify | me, farm, stre | et, factor | y, office | | 2 | 8f. Location City of | on (Street a Town, Sta | and Numbe | er or Run | al Route Number, |
| | Hospi 4 hour Funer tely fill | Medical (| 29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa | hysician: To the bes miner: On the basis and manner s | of examinati tated. | wledge, death ion and/or inv | occurred estigation | at the time | e, date ar inion, dea | nd place, at ath occurre | nd due to d at the ti | the cause ne, date a | (s) and mar nd place, a | nner as s and due t | stated. the cause(s) |
| | To the within 2 To the complei | Σ | 29b. Signature and title of certifier | 1. Chotan | 2 | | 29 | c. License | | | - | | | | Day, Year) |
| , | 12 | | P 1 | | | | | D5885 | o3 | | | NOV | EMBER | 7, | 2005 |
| | nes | | 30. Name and address of person who DR. HABIB CHOTAN | | | | | ne or | | רואג דכ | N/A IDT | יוא א | 21 E | n2 | |
| | Sta | te | DR. HABIB CHOTAN 31. Date filed (Month, Day, Year) | | VIVSYLV trar's Signat | | VEINC | E CL | JIMBE) | RLAND | MAKY | LAND | 215 | 02 | |
| | Renistr | | NOV 1 4 20 | | _ | 1. 1 | 24.0 | | | | | | | | |

| | | | 1 - For State Registrar | State of Ma | aryland | | artmen <i>tificate</i> | | | | | giene Reg. No | | 5 | 3838 | 55 |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------|-------------------------------|----------------------------|-------------------------|----------------------------|----------------------------|---------------------------------|------------------------|-----------------------|--------------------------|-----------------------------------------------|-------------------|
| | ° Physici | | 1. Decedent's Name (First, Middle, Last | Comm | | | | | | | 2. Date of Dea | | , | Year | 3. Time of 0 | |
| | Examin | | 4a. Facility Name (If not institution, give | | | | 4b. City, | Town, or | Location of | of Death | , , | 4c. | County o | | | |
| - 50 | * | 4 | Carroll Hospit | al Cente | r | | West | min | ster | : | | C | arro | 011 | | |
| | Funeral | | 5. Social Security Number 6. Se | x 7. Age | e (In yrs. la | st birthday) | If Under Months | 1 Year Days | If Under | Min. | 8. Date of Birt (Month, Da | h v. Year) | | 9. Birthpl Count | | Foreign |
| | Director | | Usual Residence of Decedent | X 2 | 79 | Yrs. | | | | | 11/25/ | 192 | 5 | WV | | |
| | land ow | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | | | 10 | d. Inside City | Limits |
| | Man, | tor | MD Howard | | Col | umbia | 1 | | | | | | | | 1 XYes | 2 □ No |
| | n the | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Cit | zen of Wi | hat Count | try? | |
| | death with the Maryland ms 23s or 28a-f show rmst ke rodiffied st | al | 8220 Snowden R | iver Par | kway | | 21 | 045 | | | | | U.S. | • | | |
| | tems | Funeral | 11. Marital Status | 12. Was Decedent ! Armed Forces? | | | Was Deced f Yes, spec | ent of His | spanic Origin, Mexican | gin? (Spec | cify Yes or No- lican, etc.) | - | 14. Race Black | - America | | |
| 36 | s afte | by Fi | 1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced | 1 □XYes 2 □ N If Yes, Give Year or Dates: | 10 | | I□Yes 2 | No | Specify: | | | | Specify: | | | |
| 8 | filed within 72 hours after Hygiene. Hygiene. other then "neturel", or Itel | ed b | 15. Decedent's Edi | | | 16a, Deced | lent's Usua | I Occupa | tion | | | 16h Ki | nd of Bus | | | |
| 15 | n "ne n "ne | plet | (Specify only highest grade Elementary/Secondary (0-12) | le completed) | | (Give life. L | kind of wor OO NOT us | k done d e retired) | uring most | t of workin | g | 100.70 | na or bas | 111033/1110 | ustry | |
| 212 | d with giene ar the | Completed | 8th | College (1-4or 5 | (+) | Mech | nanio | Fo | rman | ì | | | Lumk | er | | |
| 2 | al Hy f other | Bec | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mothe | r's Name | (First, Middle, | Maiden | Sumame |) | | |
| Maryland 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23s or 28a-f show other treumetic event. The Medical Examiner must be routined at | 2 | Robert Earl Gr | | | | | | | | Pearl | | | | | |
| Jar | 2 sh and is m reum | | 19a. Informant's Name/Relationship (T) | ype, Print) | 1 | | | | | | Route Numbe | | | | | |
| e, | 1 and Healti em 2 thar 1 | | Gloria Murphy 20a. Method of Disposition | | 20b. Pla | 3311 ace of Dispo | Aug sition (Nam | usta ne of | a Ro | | Manche | | er, | | 211(|)2 |
| Jou | ages nt of l t: if it | | 1 XBurial 2 ☐ Cremation 3 ☐ I | | Сві | metery, cren | natory or or | her place | · | 11/1 | 7/05 | | | • | | |
| altimore, | permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or othar tre pnce. | i | 4 □ Donation 5 □ Other (Specify,21. Signature of Funeral Service Licens | | Ter | ra Al | Name and | d Addres | s of Facilit | · · | | | | | , WV | |
| Ba | Depire Impe | | 19milt Athan | By L # | 1010 | 35 7 | rthu | ir H | i Wr | ight | Fune Fune | ral | Hou | ne | WV 26 | 761 |
| 100 | Pnysician | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition | lications that caused ne cause on each lin | the death. | | er the mode | | | | | | ATC | | Approximate Interval Betwo Onset and De | een |
| | /Medical Examiner | | resulting in death) | Due to (or as | | ence of): | Full | | | | | | | | | |
| | n = | ner | Sequentially list conditions, if any Isaama to immediate cause. Enter Underlying | b. Due to (or as | | | | | | | | | | | | |
| | acuted ind transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Advance | ced | A1th | eine | 15 | den | centr | en | | | | | |
| 90, | oe execian a | Ě | resulting in death) cast | Due to (or as | a conseque | ence of): | . 4 | | 4 . | | | | | | | |
| 928 | icate be executed physician and s the burial-transit | dical | | a possibi | u ru | 130 pl | rary | <u> 1910</u> | um | uass. | | | | | | |
| .O. Box (| The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physiclan/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal c | death 3 | Ectopic pre | | | | | 2 | 23d. Date Monti | | y Day Ye | ar |
| Q | that the de led by the a detached f | Ph | Part II. Other significant conditions co | ntributing to death be | ut not result | tina in the ur | nderlying ca | usa diva | n in Part I. | | 23e. Did to | bacco u | se contrib | ute to the | cause of dea | ath? |
| Records, | w requires that been signed should be det | ted by | Coronary arter | | | | | | | | 1 □ Y | es 2 | (N₀ 3 | ☐ Proba | bly 4 ∐Un | known |
| Reco | he law r s has be ige 2 sh | Completed | | | | | | | | | 24a. Was a autop perfor | | pri de: | or to com ath? | sy findings av pletion of cau | ailable ise of |
| Vital | ysiclen: The l is certificate ha director, page | | 25. Was case referred to medical | | | | | | 26 Place | of Death | 1 ☐ Yes (Check only or | - | 1 L | Yes 2 | P□ No | |
| > | ysick is cer | To Be | examiner? 1 ☐ Yes 2 No | Hospital: | nt 2 E | R/Outpatien | 3 DO | Otho | | | e 5 ☐ Resid | | Other | (Specify) | 1 | |
| Division of | 는 부 등 | atlon: | 27. Manner of Death ↑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injur (Month, Day | Year) 2 | 28b. Time of Injury | 28 M | Bc. Injury Work' | at | 28 | 3d. Describe h | | | | | |
| Divis | To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injubul | ury - At hom c. (Specify) | ne, farm, stre | eet, factory | , office | | 28 | 3f. Location (S City or Tow | treet and n, State, | d Number | or Rural | Route Numbe | ∋r, |
| | te Hospit 24 hour 16 Funer | edical | 29a. Certifier (Check only one) Certifying Physical Exami | sician: To the best of iner: On the basis of and manner sta | examination | ledge, death on and/or inv | occurred a restigation, | at the time in my op | e, date and inion, deat | d place, ar th occurred | nd due to the o | ause(s) date and | and manr place, an | ner as sta d due to t | ted. he cause(s) | |
| | To the within to the comp | Ř | 29b. Signature and title of certifier | - | | | | License | | | | | signed (| Month, D | ay, Year) | |
|) | | | Kweinaar | 40 | | | ſ, | 0006 | 297 | 5 | / | 11/13 | 105 | | , | |
| | | | 30. Name and address of person who co | 4 | eath (Item 2 | 23a) (Type, I | Print) | (| | | la ce | | | | | |
| | | | 31. Date filed (Month, Day, Year) | 32. Registra | Trans | - AVE | rue | 301 | H # | 307, | Mest | min. | ste- | MD | 21157 | |
| | Sta Registr | _ | | 005 | o orginatu | A A | formall. | g Ś | | | | | | | | |

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| | | | For Stata Ragistrar | State of Maryl | | artment of F | | | giene leg. Na2 0 (| 15 38367 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------|
| Ċ, | Physici | | 1. Decedent's Name (First, Middle, La Mark S. Gambone | ast) | | | | 2. Date of Dea Month Novembe | th Day | 3. Time of Death |
| + | /Medi Examir | | 4a. Facility Name (If not institution, git 1222 Cherry Tree | Lane | | 4b. City, Town, or Annapol | is | th | 4c. County o | rundel County |
| ē. | Funeral Director | | | | Yrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | . (Month, Day | 1, 1961 | 9. Birthplace (State or Foreign Country) Maryland |
| | death with the Maryland ma 23a or 28a-f ehow I must be notified at | ctor | 10a. State 10b. County Maryland Anne A | | City, Town or Lo | | napolis | | | 10d. Inside City Limits 1XX es 2 □ No |
| • | th with the 23a or 28 | i Director | 10e. Street and Number 737 Warren Drive | | | 10f. Zip Code | 21403 | | Og. Citizen of Wh | nat Country? |
| 920 | hours after death witt tural', or Itema 23a o | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Microced | 12. Was Decedent Ever in Amed Forces? 1 (32Yes 2 □ No If Yes, Give Year or Dates: 198 | | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No | ispanic Origin? (n, Mexican, Pue Specity: | Specify Yes or No- to Rican, etc.) | | - American Indian, White, etc. White |
| Maryland 21215-0036 | in 72 | Completed | 15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) | ducation ade completed) College (1-4or 5+) | (Give | dent's Usual Occupi kind of work done o DO NOT use retired Omputer A | turing most of wo) | rking | 16b. Kind of Busi | puters |
| yland | 2 should be filed withing and Mental Hygiene. Ie marked other there aumatic event, the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the M | To Be C | 17. Father's Name (First, Middle, Las. Ralph F. Gambo | - | | | | me (First, Middle, Angelind | | |
| | 5 E 7 E | | 19a. Informant's Name/Relationship Ralph Gambone/f | ** * | | ng Address (Street a Warren D | | ura <i>l Route Numbel</i> napolis, | | |
| Baltimore, | 00- | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci | Removal from State | - | sition (Name of matory or other place Mem. Gare | · | Date /10/2005 | 20c. Location - C | ity or Town, State |
| Balt | permit. Pag Department Important: I eny injury o | | 21. Signatur of Funery Service Lice | , delle | en 14 | 17 Duke o | s of Facility Jo f Glouce | hn M. Tay ster St., | ylor Fund , Annapol | eral Home lis, MD 21401 |
| 8760, | Physician be executed physician and physician and Examiner and Examiner the brutal-transit | dicai Examiner | 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Saluentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Coutacy | sequence of): | er the mode or dyin | OU4 L | to li | est | Approximate Interval Batween Onset and Death |
| .O. Box 6 | The law requires that the death certificate be execut ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of | etal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of Month | |
| 0 | w requires that been signed b should be deta | þ | Part II. Other significant conditions | contributing to death but not | esulting in the u | nderlying cause give | in in Part I. | 23e. Did tot | | ute to the cause of death? |
| al Records, | i: The law ri icate has be r. page 2 sh | Completed | | | | | | 24a. Was a autops perform 1 X Yes 2 | y prid ned? dea | ore autopsy findings available or to completion of cause of ath? Yes 2 No |
| Division of Vital | To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Certification: To Be | 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending investigation 3 ☑ Suicide 6 ☐ Could not be determined | 28a. Date of Injury (Month, Day Year, | thome, farm, str | 28c. Injury Work | ^{III} : 4 ☐ Nursing H | Subje | once 6 Other ow injury occurred H She f reet and Number of, State) | |
| | Hospita 24 hours Funeral | Medical C | 29a. Certifier (Check only one) | nysician: To the best of my k ninar: On the basis of exam and manner stated. | nowledge, death | occurred at the time restigation, in my op | e, date and place inion, death occu | and due to the ca | use(s) and mann | er as stated. If due to the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier Zc. Liu | completed cause of death (I | em 23a) (Type | 29c. License OC | | | November | Month, Day, Year) 7, 2005 aryland 21201 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32 Registrar's Sig | 7 | and the | | | |) |

ORIGINAL

| | | | For State | State of Mary | | artment of H | | - | / 11115 | 38368 |
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| | | | Registrar 1. Decedent's Name (First, Middle, La: | st) | | Timodio or E | Journ | 2. Date of De | Reg. No. | 3. Time of Death |
| | Physici /Medio | al | Madeleine M. Gal | lant | | | | NOVEN | | |
| 7 | Examin | er | 4a. Facility Name (If not institution, give | 4 4 | 1 | 4b. City, Town, or | Location of | Death | 4c. County of Dea | |
| | | | BROOKE GROVE KETI | | | If Under 1 Year | If Under 24 | Hrs 8 Date of Bird | | GOMERY |
| П | Funeral | | 5. Social Security Number 6. S | □M 2ÐF | yrs. last birthday) Yrs. | Months Days | Hours | Min. (Month, Da | | rthplace (State or Foreign ountry) |
| | Director | | 020-05-9795 Usual Residence of Decedent | 87 | | | | July 30 | 0,1918 Nev | / Hampshire |
| | and ** | | 10a. State 10b. County | 10 | c. City, Town or Lo | ocation | | | | 10d. In side City Limits |
| | Aanyl f sho | ō | M 1 M | | C | C | | | | 1 ☐ Yes 2 ☑ No |
| | 28a- | ect | Maryland Montgome | ry | Silver | 10f. Zip Code | | | 10g. Citizen of What C | ountry? |
| | with Ba or | by Funeral Director | | . w.o.o.t | | | 2090 | 11 | USA | |
| | ns 23 | era | 9618 Evergreen St | 12. Was Decedent Ever | in U.S. 13. | Was Decedent of Hi | | n? (Specify Yes or No Puerto Rican, etc.) | | erican Indian, |
| | ther d | F | 1 ☐ Never Married 2 ☑ Married | Armed Forces? 1 ☐ Yes 2 ☐ No | | | n, Mexican, | Puerto Rican, etc.) | Black, Whi | te, etc. |
| 336 | ers a | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☑ No | Specify: | | Specify: | hite |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show ta Medical Exami na must be notified at | Completed | 15. Decedent's Ed | lucation | 16a. Dece | dent's Usual Occupa | ation | d working | 16b. Kind of Business | |
| 215 | 7 nin 7 | ple | (Specify only highest gra | College (1-4or 5+) | life. | kind of work done of DO NOT use retired | iuring most (f) | or working | | |
| 21 | d with giene. | Į, | | 3 | Lega1 | Secretar | у | | Insurance | |
| | be filed tal Hygi d other event, t | Be (| 17. Father's Name (First, Middle, Last, | | | | 18. Mother | s Name (First, Middle, | Maiden Sumame) | |
| Maryland | Mental Mental arked carked catic even | 2 | Napoleon Masse | | | | Wil | da Carti | er | |
| ary | 2 sho and N Is ma | • | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Maili | ng Address (Street a | and Number | or Rural Route Numbe | er, City or Town, State, | Zip Code) |
| | es 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. I filem 27 is marked other than "naturel", or liems 23a or 28a-f show tiem 27 is marked other than "naturel", or liems 23a or 28a-f show the fraumatic event, the Medical Examinar must be notified at the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of th | | Wayne W. Gallant | Husband | | Evergree | n Stre | et Silver | Spring, Ma | ryland 20901 |
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| Baltimore, | permit. Pages Department of Importent: If i eny injury or once. | | 21. Signature of Funeral Service Licer | IS88 | 2 | 2. Name and Addres | s of Facility | | • | • |
| m | | | + Keir Skiles | | 5 | 00 Univer | sity F | ns runeral BlvdWSi | Home, Inc 1ver Sprin | e.MD 20901 |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the | death. Do not en | ter the mode of dyine | g, such as ca | ardiac or respiratory ar | rest, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | EATIL O | CANYFO | WIT | H META | CTACES | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a co | | | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 1311/263 | 13 /00/01/13 |
| | Examiner | | Communicible list conditions | h | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a co | onsequence of): | | - | | | |
| | ate be executed hysician and he burial-transit | Examiner | Cause (Disease or injury that initiated events | c | | | | | | |
| Ö, | be execu ician and burial-tra | Ä | resulting in death) Last | Due to (or as a co | nsequence of): | | | | | |
| 3760, | ate br nysic he bi | Ical | | d | | | | | | |
| 89 | death certifica e attending ph od for use as th | Med | IF FEMALE: | | | | | | | |
| Box | attendin for use | an/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of p 1☐Live birth 2 ☐ | Fetal death 3 | ⊒Ectopic pregnancy | | | 23d. Date of de Month | elivery Day Year |
| | e dez | Completed by Physician/Med | 1 Yes 2 No | 4□Pregnant at time 9□Unknown | e of death 5[| Other (specify) | | | | , |
| P.0 | that the de led by the a detached f | F. | Part II. Other significant conditions | contributing to doub but or | at reculting in the I | and other a course and | on in Bart I | 23e Did to | obacco use contribute t | o the cause of death? |
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| orc | w requir been si should | ted | 11001101000 | 20000 | 21-7 117 | | | - | | |
| ec | a s c | nple | | | | | | 24a. Was | an 24b. Were a prior to rmed? death? | utopsy findings available completion of cause of |
| = | Th ate pag | S | | | | | | 1 ☐ Yes | 2 No 1 ☐ Ye | s 2 No |
| /its | Physicien: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | other Other | 011 | of Death (Check only o | | ASSISTED |
| of | Phys this al dir | 2 | 1 Yes 2 No | 1 L Inpatient | 2 ER/Outpatie | nt 3 DOA | 4 Nurs | | dence 6 Other (Spenow injury occurred | ecity) LIVING |
| n C | m 0 0 | o | 27. Manner of Death 1 ■Natural 5 □ Pending | 28a. Date of Injury (Month, Day Ye | ar) Injury | Worl | k? Yes 2 □ N | | low injury occurred | |
| Sig | Attending ir death. ector: After by the fune | icat | 2 Accident investigatio | | At home farm st | reet, factory, office | | | Street and Number or F | Rural Route Number |
| Division of Vital Records, | or A after Direct in by | Certification; | 4 Homicide determined | building, etc. (S | Specify) | ioot, labiory, diligo | | City or Tov | | |
| | spital | a C | 29a. Certifier 🔀 Certifying Pl | sysicien: To the best of m | ıy knowledge, dea | th occurred at the tim | ne, date and | place, and due to the | cause(s) and manner a | s stated. |
| | To the Hospital or Attendin, within 24 hours after death. To the Funerel Director: After completely filled in by the fun | edical | (Check only 2 Medical Examone) | niner: On the basis of exa and manner stated | | nvestigation, in my o | pinion, death | occurred at the time, | date and place, and du | e to the cause(s) |
| | To the vithin To the comp | ž | 29b. Signature and title of certifier | | | 29c. License | | | 29d. Date signed (Mon | |
| | 20 | | m | THENDING | PHYSICI, | AN D | 4 4 | 6 07c | JOUEMB | LR 10, 2005 MARYLAND UNG, 20860 |
| | 00 | | 30. Name and address of person who | completed cause of death | (Item 23a) (Type | , Print) | _ | 0 0 | | MARYLAND |
| | | | GRACE BROOKE 1- | ruffman, 1 | 4-12- 181 | UD SLADE | Sato | olkoad S | ANDY SPA | UNG, 20860 |
| | | ate | 31. Date filed (Month, Day, Year) | 32 Registrar's | Signature | affel of | | | - | |
| | Regist | rair | NUV 14 / | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | 1 | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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| Physician | | ecedent's Name (| | | | | | | | | 2. Date of De Month | eath Day | / Ye | ear | 3. Time of D | eath |
| /Medical | | Matthew J | | | | | | | | | Novemb | er 0 | 7, 200 | | 10:58 | P^{M} |
| Examiner | | | | give street and nu | | | 1 | | Location of | | | 4c. | County of (| | | |
| Function | | ocial Security Nur | | ty Hospit | 7. Age (In yrs. | last birthday) | If Under | | stown If Under 2 | | 8. Date of Bi | rth | Wash | | | Foreian |
| Funeral Director | | 215-29-62 | | 1 ∑ M 2□F | 17 | Yrs. | Months | Days | Hours | Min. | 06/01/ | 1988 | | Countr | ce (State or i | A |
| | | al Residence of D | | | | | 1 | | | | | | | | | |
| anylar show | _ | State 1 | 10b. County | nington | | ity, Town or Lo Iagerst | | | | | | | | 100 | d. Inside City 1X Yes 2 | |
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| uter death with the Marylan ritems 23a or 28e-f show cliner must be notified at Enneral Director | 1 | .011 Corb | | reet | | | 10f. Zip | | 740 | | | iog. Citi | zen of Wha | t Countr | y/ | |
| leath ms 23 | 11. | Marital Status | | 12. Was Dec | edent Ever in U | J.S. 13. | Was Deced | ent of His | spanic Orig | in? (Spe | cify Yes or N Rican, etc.) | 0- | 14. Race - / | Americai | n Indian, | |
| or ite | 3 | 1 Never Married | d 2 Marni | | 2 🔀 No | | If Yes, spec 1 ☐ Yes 2 | | | , Puerto I | Rican, etc.) | | | White, et | | |
| Si iii | | 3 Widowed 4 | Divorced | If Yes, G Year or D | Dates: | | 1 1 1 1 9 2 | X NO | Specify: | | | | Specify: | Whi | Lte | |
| ed within 72 hours ygiene. her than "naturat" t, Ina Madical Ext. | | (Specify | Decedent only highes | s Education t grade completed) |) | 16a. Dece (Give | dent's Usua kind of wor DO NOT us | l Occupa k done di | tion uring most | of works | ng | 16b. Ki | nd of Busin | ess/Indu | istry | |
| withii iene. rthan | E | lementary/Second | dary (0-12) | College (| (1-4or 5+) | | | lent | | | | | N/A | | | |
| be filed tal Hyg d other event, | | Father's Name (Fi | irst, Middle, L | ast) | | 1 | | | 18. Mother | r's Name | (First, Middle | , Maiden | | | | |
| Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta Menta | G | Gary Jay | Goodr: | idge | | | | | Cher | y1 A | nn Hos | feld | | | | |
| permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than any injury or other treumatic event, the Manange. | 19a | a. Informant's Nam Tesse R | | iip <i>(Type, Print)</i> s/Case Ma | nager | | | | | | Route Numb Hager | | | | | |
| 1 and Health em 27 ther t | _ | . Method of Dispo | | | | Place of Dispo | | | C DUI | | ate | , | cation - City | | | |
| ages ant of it: If it y or o | | | Cremation | 3 Removal from | State | cemetery, crei | matory or o | her place | | 1 /1 /. | /2005 | | | | | |
| oartme ortan injur | 21. | Signature of Fune | | | Gr | eenlav | | | | | ald N. | | | | | me |
| Depa Impo any ii | | 13 | - | 7 | \times | | | | | | et, Ha | | | | | iiic |
| FERE | 238 | a. Part1. Enter the shock, or heart | disease, or of failure. List of | complications that | caused the dea | | | | | | | | | 1 | Approximate nterval Between | en |
| Physician | Imr | mediate Cause (Fi | | a | tha | lomi | rol | I | Ni | in | er | | | | Onset and De | ath |
| /Medical Examiner | res | ulting in death) | | Due to | (or as a consec | quence of): | | | ı | | 9 | | | | | |
| | Sec | quentially list cond | litions, | b. Due to | (or as a conse | iuanca off. | | | | | | | | - | | |
| executed on and ial-transit | Cau | quentially list cond ny, leading to imm ise. Enter Underly use (Disease or inj t initiated events | ing jury | | , | , | | | | | | | | | | |
| | | ulting in death) La | st | Due to | (or as a consec | quence of): | | | | | | | | | | |
| ate be hysicia the bu | | | , | d | | | | | | | | | | | | |
| death certificate e attending phys of for use as the | IFF | FEMALE: | | 220 11 400 04 | | | | | | | | | | | | |
| attend for us | 23b | Was decedent p in the past 12 m | onths? | 1 Live | itcome of pregn birth 2 Feta nant at time of c | al death 3 | Ectopic pro | | | | | 2 | 23d. Date of Month | , | ay Ye | ar |
| d by the attending eletached for use a letached for use a Physician/M | | 1 Yes 2 1 9 Unknown | No | 9□ Unkr | | 30201 | J 011101 (3) | | | | | | | | | |
| The law requires that the di site has been signed by the bage 2 should be detached completed by Physic | Part | II. Other signification | ant condition | ns contributing to c | death but not res | sulting in the u | nderlying ca | iuse givei | n in Part I. | | 23e. Did | tobacco u | se contribut | te to the | cause of dea | ath? |
| en sig | | | | | | | | | | | 1 🗆 | Yes 💸 | No 3 | Probab | oly 4 ⊡Uni | known |
| The law requirected that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the second that the s | _ | | | | | | | | | | 24a. Was | | | | y findings av | |
| | | | | | | | | | | | erfe es | ormed? 2 ☐ No | Nat | 13 | □No | |
| Physicien: rthis certific ral director, To Be (|) | Was case referred examiner? | | Hospital: | | V | _ | Othe | r | | Check only | | - | | | |
| ≥ º 0 C | 1 | 12 Yes 2 No Manner of Death | 0 | 28a. Qate | | R/Outpatier 28b. Time o | | A | 4 Nur | | ne 5 🗆 Resi 28d. Describe | | | Specify) | | |
| Attending in death. Ctor: After by the funer funer filestion | | 1 □Natural | 5 Pending | Mor | nth, Day Year) | 15/6 | | 3c. Injury Work′ 1 ∐ Y | | . 1/ | hofed | drih | 1 | it, | pole | |
| or Attending Patter death. Director: Atter I in by the funera | | 3 Suicide 4 Homicide | 6 ☐ Could n determin | ned 286 Place | e of Injury - At h | ome, farm, str | | office | | - 1 | 28f. Location (| Street and | d Numby o | r Rural F | Route Numbe | ∋ Γ, |
| rs after or all bit of in Cert | 1 | | | Odilo | ang, atc. (opeo | STE | 27 | | | l | impi | 2/1 | re/iv | USON | still | پ |
| To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral Medical Certification: | 29a | (Chack only 2 | ☐ Certifying | Physician: To the kaminer: On the b | pasis of examina | owledge, deat ation and/or in | h occurred a vestigation, | it the time in my opi | e, date and inion, death | l place, a | ind due to the | cause(s) date and | and manne place, and | r as stat due to th | ed. 217 ne cause(s) | 140 |
| thin 2 the orthe omple | | one) | le of certifier | and mar | ner stated. | | 29c | License | number | | | 29d. Date | e signed (M | lonth. Da | tv. Year) | |
| E 3 E 8 | 3.00 | 1/1/ | Low | Do .11 | | | | | C.M.E. | | | | mber (| | | |
| | 30. | Name and address | s of person | o completed | | m 23a) (Type, | | | | | | | | | 2007 | |
| 1-4 | 5 | TUAK | en | Loyce | | 111 Per | | eet, | Balt | imoı | ce, Mar | rylan | d 212 | 01 | | |
| State Registrar | | Date filed (Month, | Day, Year) | | Registrar's Sign | | 1.0 | | | | | | | | | |

| , | | | Registrar MD'sSupervis | | nd / Depa boo <i>Ce</i> a | artmer rtifica | nt of H | ealth a Death | | F | Reg. No. | 000 | | 370 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------|---------------------------|-----------------------------------------|---------------------------|----------------------------------|-------------------------|---------------------------|----------------------------------------|-------------------------|
| 16. | Physici | an | 1. Decedent's Name (First, Middle, La. | | iugni | | | | 2 | Date of Dea Month | ith II-C Day | 03-2005 Yea | | of Death M |
| | /Medic | | Henry Kui 4a. Facility Name (If not institution, give | | rugiii | 4b. City | . Town, or | Location of | Death | -11 | 4c. 0 | County of De | | U W |
| \$ | Examin | er | Shady Grove Ad | | | | | ville | | | | ontgo | | |
| | Funeral Director | | 5. Social Security Number 576-18-0818 1 | ex 7. Age (In yrs. ▼ M 2□F 80 | . la <i>st birthday)</i> Yrs. | If Unde Months | r 1 Year Days | If Under 2 Hours | Min. | Date of Birtle Month Day | 1925 | 9. E | Birthplace (State Country) awaii | e or Foreign |
| | Maryland I-f ehow | tor | 10a. State 10b. County MD Montgo | | ity, Town or Lo | ocation | | | | | | | i | City Limits |
| | h with the | ai Direc | 10e. Street and Number 12003 Titian V | Vay | | 10f. Zi | 2085 | 54 | | | 10g. Citiz | en of What USA | Country? | |
| 5-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow minglound in July or other traumatic event, the Medical Exeminal must be notified at annex. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ∑Yes 2 ☐ No IfYes, Give WWIII Year or Dates: | | Was Dece If Yes, spe 1 Yes | | ispanic Orig n, Mexican, Specify: | in? (Spec Puerto Ri | fy Yes or No- can, etc.) | | Black, W Specify: I | Pacifi | С |
| 21215-0 | ithin 72 ho ne. nen "netur Medical | Completed | 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) | | life. | kind of we DO NOT L | ork done d ise retired | during most) | of working | | | d of Busine: | , | |
| 2 | Hygier Hygier Ther th | Co | 17. Father's Name (First, Middle, Last) | 5+ | Vı | ce C | naıı | | 's Name / | First, Middle, | | | Relati | ons |
| Maryland | d Mental be f | To Be | Alfred Walter 19a. Informant's Name/Relationship (| Giugni | 10b Mailie | an Addrag | a (Stance) | Kea | loha | Hook | ano | | 7:0-1-1 | |
| | ulth an 27 is r | | Muriel R.Giugi | | | | | | | Route Numbe Stomac | - | | | |
| altimore, | of Head | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ | | Place of Dispo cemetery, crei | sition (Na | me of | | Da | | • | | or Town, State | |
| Ĕ | tment tant: I | | 4 □ Donation 5 □ Other (Specif | N) A) | Chesap | eake | Cre | em. 1 | 1/05 | 5/05 | Bel | tsvil | lle,Md | |
| Ba | permit Depar Impor any in | | 21. Signatur Uneral Service Dicer | red ' | 9 | 241 | Colu | ımbia | BL | d.Sil | ver | | CE,P. | |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or com shock, or healt failure. List only Immediate Cause (Final disease or condition resulting in death) | plications that caused the deal one cause on each line. a | 515 | ter the mo | de of dying | g, such as c | cardiac or | respiratory arr | rest, | | Approxim Interval B Onset an | etween |
| 8760, | The law requires that the death certificate be executed at has been signed by the attending physician and cage 2 should be detached for use as the burial-transit | dical Examiner | Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consect d. | | | | | | | | | | |
| P.O. Box 6 | that the death certific ed by the attending pl detached for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o | al death 3 | Ectopic p | | | | | 23 | 3d. Date of o | lelivery Day | Year |
| | quires that in signed b uld be deta | b | Part II. Other significant conditions of | ontributing to death but not re | sulting in the u | nderlying | cause give | en in Part I. | | | bacco us | | to the cause o | |
| Division of Vital Records, | The law requir ate has been si page 2 should | Completed | | | | | | | _ | 24a. Was a autops perfor | sy | 24b. Were prior to death | | s available cause of |
| Zita Zita | ician: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | Cthe | 0.00 | • | Check only or | | | | |
| ō | Attending Physician: or death. actor: After this certifica by the funeral director, p | 7: To | 1 ☐ Yes 2€ No 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | ER/Outpatier 28b. Time of | | OA Injury Work | 4 🗆 Nur | | 5 Resid | | | pecify) | |
| ion | ath. vr: Afte | atio | 1 | 1 | Injury | М | | <br Yes 2 □ N | lo | | | | | |
| D N | tal or Atters after de al Diracto | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Place of Injury - At I building, etc. (Speci | nome, farm, str ify) | eet, factor | y, office | | 28 | f. Location (S City or Tow | treet and n, State) | Number or | Rural Route Nu | ımber, |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | edicai | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best of my kn niner: On the basis of examin- and manner stated. | owledge, deat ation and/or in | h occurred vestigation | at the tim | ne, date and pinion, death | l place, an n occurred | d due to the c at the time, d | ause(s) a late and p | nd manner place, and d | as stated. ue to the cause | o(s) |
| | To the within To the comple | Σ | 29b. Signature and title of certifier | 1.D- | | 29 | c. License | | 3 | | | | nth, Day, Year) | |
| | | 1 | 30 Name and address of parson :: to | completed cause of death (tea | m 23a) /T | Print) | 05 | 26 | | | 11/ | 5,05 | | 2-1-1 |
| | Sta | to | 30. Name and address of person who have a supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the supply of the su | DRSLIM 32. Registrar's Sign | D-0 | 1901 | M. | EDIC | CAL | CEN | JTE | IR I | s Drivi | - MD |
| | Registr | | NUV 0'9 | 2005 | Is A | parke | 1 | | | | | | | |

| | | | 1 - For State Registrar | ate of Maryland | | artment of H | | lental Hygie | ene 2005 | 5 38371 |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------|-------------------------------------------------|--------------------------------------------|-------------------------------------------|----------------------------------|---------------------------------------------------------------|
| | Physici | ian | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death Month | Day | 3. Time of Death |
| - | /Medi | | James B. Goodha | | | | | November 1 | 6, 200 | 05 11:45 A M |
| | Examir | ner | 4a. Facility Name (If not institution, give stree | , | | | Location of Death | | 4c. County of | |
| | Cunaval | | 931 Edgewood Rd., Ap 5. Social Security Number 6. Sex | 7. Age (In yrs. last) | birthday) | Annapo | If Under 24 Hrs. | 8 Date of Birth | | e Arundel |
| н | Funeral Director | | 216–20–0083 | | Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day,) 7-20-192 | (ear) | 9. Birthplace (State or Foreign Country) Mary Land |
| | P. | | Usual Residence of Decedent | | | | 1 | | | and plants |
| | be filed within 72 hours after death with the Maryland nat Hygiene. do other then "natural", or Iteme 23a or 28a-f show event, the Mcdreal Examinar must be notified at | Director | Maryland Anne Arund | lel 10c. City, To | | napolis | | | | 10d. Inside City Limits 12 Yes 2 □ No |
| | or 28 | Ole Pire | 10e. Street and Number | | | 10f. Zip Code | | 100 | . Citizen of Wh | nat Country? |
| | ath w | ra | 931 Edgewood Rd., A | | | 21 403 | | | USA | |
| | ltem Item | Funeral | , A | Vas Decedent Ever in U.S. med Forces? | 13. | Was Decedent of His If Yes, specify Cubar | spanic Origin? (Spe n, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | - American Indian, White, etc. |
| 36 | irs aff | by F | | ፟MYes 2 □ No Yes, Give 'ear or Dates: W . W . I] | - | 1 ☐ Yes 2 💆 No | Specify: | | Specify: | White |
| ğ | 2 hou | | 15. Decedent's Educatio | 1 16 | a. Dece | dent's Usual Occupa | tion | 16 | b. Kind of Busi | |
| 21 | within 7 ene. then "n | pje | (Specify only highest grade cor Elementary/Secondary (0-12) | ollege (1-4or 5+) | (Give life. | kind of work done di DO NOT use retired) | uring most of worki | ng | | , |
| 2 | filed within Hygiene. Ither then ent, the Me | Completed | | years | Acc | countant | | | Fina | ncial |
| nd | tal Hydoth | Be | 17. Father's Name (First, Middle, Last) | 71 7 0 | | | 18. Mother's Name | | iden Sumame) | |
| Z | 2 should be and Mental le marked (| ဥ | James B. Go | | | | | a Tyson | | |
| Maryland 21215-0036 | | 61 4 | 19a. Informant's Name/Relationship (Type, F | | 9b. Mailir | ng Address (Street a | nd Number or Rura | l Route Number, C | City or Town, St | ate, Zip Code) |
| | ss 1 and of Health item 27 other tr | | Laura C. Goodhand/Da 20a. Method of Disposition | ughter | | Newbridge | | | | T |
| 10 | Pages nent of P ant: If its ary or o | | 1 ☐ Burial 2 【Cremation 3 ☐ Remo | /al from State ceme | tery, crer | natory or other place | 11-7- | 2.0 | | ity or Town, State |
| Baltimore, | 4 E E E | | * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licensee | Natas | | ematory | 1 | | dgewate | • |
| Ba | perm Depa Impo any i | | VIII Cluc | | 29 | 73 Solomo | ons Island | d Rd. Edg | gewater | uneral Home , MD 21037 |
| П | | | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care | ns that caused the death. Duse on each line. | o not ent | er the mode of dying | , such as cardiac o | r respiratory arrest | , | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | My D card | -iak | Int | arction | | | M. NUTCI |
| | /Medical Examiner | | Tosoning in death) | Due to (or as a consequence | e of): | | | | | |
| | | Ē | Sequentially list conditions, b. — | Due to (or as a consequence | e of): | | | | | |
| | uted J insit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | /- | | | | | |
| Ć | execute and and ital-tra | Еха | that initiated events resulting in death) Last | Due to (or as a consequenc | e of): | | | | | |
| 8760, | cate be executed physician and the burial-transit | | d. | | | | | | | |
| Ö | certifica nding ph use as th | Jed | IS SERVICE | | | | | | 1 | |
| Вох | leath certific attending p | Physician/Medical | 20b. Was decedent program | yes, outcome of pregnancy □Live birth 2 □ Fetal dea | th 3 | Ectopic pregnancy | | | 23d. Date of | , |
| 0 | 0 0 0 | SIC | 1 Ves 2 No | ☐ Pregnant at time of death ☐ Unknown | | Other (specify) | | | Month | Day Year |
| Ρ. | that the | Phy | | ing to doub but not not be | | | | an Billi | | |
| Š, | se ng ed | by | Part II. Other significant conditions contribu | ang to death but not resulting | ın ine ur | ideriying cause giver | n in Part I. | | | ute to the cause of death? |
| Vital Record | w requir been si should | Completed | | | | | | | 2 No 3 | Probably 4 Junknown |
| 3e | e la has | mp | | | | | | 24a. Was an autopsy performed | prio | re autopsy findings available ir to completion of cause of |
| <u></u> | 10 | | 05.10(-) | | | | | 1 ☐ Yes 2 € | | Yes 2□ No |
| ⋚ | or Attending Physicien: after death. Director: After this certification by the funeral director, | o Be | 25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) Hospit | al: 1 ☐ Inpatient 2 ☐ ER/C |)t==ti== | t 3 DOA Other | 26. Place of Death | _ | | |
| of | Phy eral d | - | 27. Manner of Death 28 | a. Date of Injury 28b. | Time of | 28c. Injury a | 4 Iduising Hon | ne 5 Residence 8d. Describe how | | (Specify) |
| o | ath. r: Afte | atlo | 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | | es 2 □No | | | |
| Division | Atte | ifica | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28 | e. Place of Injury - At home, building, etc. (Specify) | farm, stre | eet, factory, office | 2 | 8f. Location (Stree | t and Number | or Rural Route Number, |
| Ö | tel or A rs after el Dire ed in by | Certification: | T I I I I I I I I I I I I I I I I I I I | building, etc. (Specify) | | | | City or Town, S | iaie) | |
| | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer | edical | (Check only 2 Medical Examiner: (| : To the best of my knowled on the basis of examination a nd manner stated. | ge, death ind/or inv | occurred at the time restigation, in my opin | , date and place, a nion, death occurre | nd due to the caus d at the time, date | e(s) and manne and place, and | er as stated. I due to the cause(s) |
| | To the within 2 To the Complet | Me | 29b. Signature and title of certifier | | | 29c. License | number | 29d. | Date signed (A | Month, Day, Year) |
| | | | panel (Ina | > KD | | D1609 | 364 | 1 | 1-7-0 |) (|
| | | | 30. Name and address of person who comple | ed cause of death (Item 23a |) (Туре, Г | Print) | 4 | | . , , | • |
| | - | | James Checona | | tch | ie Hwy | , An | nold, v | LD 2 | 1012 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32 Registrar's Signature | A | | | . , | | |
| | Registr | ar | MDV 0 8 2005 | METERS ST. | 1 | | | | | |

RICHARD FOSTER GORNALL Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-07655 State of Maryland / Department of Health and Mental Hygiene, RJCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year RICHARD FOSTER GORNALL /Medical 12, 2005 4c. County of Death November 1:30 p. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Memorial Hospital Cumberland Allegany County If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1**X** M 2□ F Yrs Director 214-28-6948 76 JUNE 22,1929 MARYLAND Usual Residence of Decedent with the Maryland or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XXNo MINERAL FORT ASHBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 2 109 JAMIE STREET 26719 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: The Mudical Exac 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygien Important: If item 27 ie marked other tt eny or other treumatic event, ITEM 2008. AIRCRAFT MECHANIC 12 EASTERN AIRLINES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANK GORNALL MARGARET SOWERS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 JAMIE STREET, THELMA GORNALL / WIFE FORT ASHBY, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CUMBERLAND CREMATORY 11/15/2005 CUMBERLAND, MD 21. Signature of Funeral Service Licenses UPCHURCH FUNERAL HOME, INC. 4D Chelle P.O. BOX 1260, FORT ASHBY, WV 26719 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. HyperAcustre 6th atherosclevone /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed signed by the atlending physician and deep betached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 0.0 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à should be diabetes mellits 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1☑ Yes 2☐ No 24a. Was an certificate 10 Yes 2 No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1X Yes 2 □ No 2 X ER/Outpatient 3 DOA Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**XMedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

24/1

31. Date filed (Month, Day, Year) State

idsha

29b. Signature and title of certifier

NOV 1 5 2005

Zareenbera Mild 32 Begistrar's Signature

MP

30. Name and address of person to completed cause of death (Item 23a) (Type, Print) 111 Penn Street

29c. License number

OCME

29d. Date signed (Month, Day, Year)

November 13, 2005

Baltimore, Maryland 21201

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Esther Goodfellow /Medical NOVEMBER 14 2005 1728 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗓 F 93 Director 217-10-4098 01/27/1912 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location or 28a-f show 10d, Inside City Limits r than "natural", or itams 23a or 28a-f ahov the Medical Examinar crust by notified at Director 1 ☐ Yes 2 📉 No Hampshire Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 163 26763 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Be Completed by Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tire and Rubber .. Pages 1 and 2 should be filed v thent of Health and Mental Hygie tant: If item 27 le marked other t ijury or other traumatic svent, ID 10 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .Tames Kessel1 Maggie Maude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Bible / daughter P.O. Box 162, Springfield, West Virginia 26763 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory 11/15/2005 Cumberland, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CERSBROVASCULAR ACCIDENT **Physician** 224 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760. attending physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 1 No 3 Probebly 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performeda rs after deau...
ral Director: After this ce....
in by the funeral director. pr 2 1 No Be 25. Was case referred to medical 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending М 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14865 NOVEMBER 15, 2005 30. Name and address of person who completed cause of death (Item 234) (Type, Print) nds ROBUSTIANO BARRERA, M.D 500 MEMORIAL AVENUE CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) NOV 1 5 2005 3 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygier 38374 1 - For State Registrar Certificate of Death Rag. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Sarah Ruth Gable (AKA Sarah Esther Gable) 20 /Medical 2005 12:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frostburg Village Nursing Home Allegany Frostburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🕅 F Months Hours Yrs Director 217-74-2275 05/15/1917 West Virginia Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location itam 27 is markad other than "naturat", or itams 23a or 28e-f show other traumatic event. The Medical Examitm runst by notified at 10d. Inside City Limits MD Director Allegany 1 ☐ Yes 2√ No Cumber land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10710 Old Johnson Road, N.E. 21502 USA death Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat', or ite, any injury or other traumatic evant, the Medical Examination. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 💢 No Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Llovd Weslev Spring Frances Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn F. Rice / daughter 715 Leiper Street, Cumberland, Maryland 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 11/23/2005 Cumberland, Maryland 21. Signature of F neral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RAFRAST CARCINIMA actor 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by OR STRUCTIVE LUNG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ dinknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death | Diractor: ... d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aff To the Funeral Di completely filled in 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 21, 2005 126907 Hudlin 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAD Harjit S. Sidhu, M.D. 925 Bishop Walsh Drive, Cumberland, Maryland 21502 31. Date filed (Month, Day, Year), NOV 21 32. Posistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiep 0.5Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 1852 M Doris Hudson E. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Nicanico SALISBURY WONd ENIKU IA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11-11-1917 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2180 F 87 Yrs. Maryland Director 222-03-0683 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified at 1 Yes & No Directo Worcester Maryland Bishopville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 10239 Hotel Road 21813 US by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp ade completed) Paper Hanging Elementary/Secondary (0-12) Coltege (1-4or 5+) Wall Paper Hanger 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Wimbrow Launa Murray ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granville Hudson/ Son 10239 Hotel Rd, Bishopville, MD. 21813 20b. Place of Disposition (Name of Cape HenTopen Crematory of other place)
Crematory 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 1 Burial 4 □Dopation 5 ☑Other (Specify) 11-14-05 Frankford, Delaware 21. Signature of Funeral Selvice licens Me Ison funeral Services, Ltd. Thatcher St, Frankford, Delaware. 19945 23a, Part1. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown 9 Unknown sete has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificete has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician; After this certification, funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 3 ☐ Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 34768 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) WIELAND, M. D. JALISBURY Md. 21801 IONE. CAPPOLL ST. JEFFREY 31. Date filed (Month, Day Registrar's Signature State Sperte Registrar

John Handy 05-7561 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** JOHN M. HANDY November 7 2005 7:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OI/20/34 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
VA **Funeral** Days Months Hours 1 → M 2 □ F 71 Director 231-62-9840 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-1 ehov traumatic event, the Nadical Examiner must by mytified at Yes 2 No Directo VA Accomack Horntown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23395 USA Horntown Circle Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 20XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sewell Handy, Sr. Victoria Townsend Handy ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) with Pages 1 continued of Health continued of Health continued of Health continued of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the tran P.O. Box 13, Horntown, VA 23395 Virginia Davis, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 PemovaL from State permit. Page Department of Important: If any Injury or 11/12/05 4 □ Donation 5 □ Other (Specify) Dea's Chapel Cem. Horntown, VA Signature of Funeral # 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accomac, VA Enter the disease, or complications that each in the disease on each in the cause on each in the cause on each in the cause on each in the cause on each in the cause on each in the cause on each in the cause on each in the cause on each in the cause on each in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): burial-transit certificate be executed and Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 🗌 Yes 3 Probably 4 □Unknown No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 2 \(\text{No} \) Yes 2□No After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death C Hospital: 1 ☐ Inpatient Other: Medical Certification: To 1 XYes 2 □ No 2€ ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month) Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 3 Division 1 Natural 5 Pending death. 1 Tes investigation filled in by the fu 2 Descrident 6 ☐ Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide (Street and Number or Rural Route Number own, State) 4 Homicide determined after within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check or 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu O.C.M.E. November 8, 2005 completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (N State 2005 Registrar

| | | | 1 - For State Registrar | State of | Maryland / [| - | artmen <i>tificate</i> | | | | | giene | nns | , | 38377 |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------|-------------------|-------------------------------------------------|------------------------------------|--------------------------------------|----------------------------|-------------------------------------------|-----------------------|--------------------------------------|------------------------|----------------------------------------------------|
| | Physici /Medic | | 1. Decedent's Name <i>(First, Middle, I</i> Harold | .ast) | 1 | Halp | oern | | | | 2. Date of Dea Iovembe | | 4, 200 | 75 | 3. Time of Death 9:02A. M |
| | Examin | | 4a Facility Name (If not institution, a Suburban Hospita | | per) | | Beth | rown or esda | Location of | | | | County of I | Death DMC1 | У |
| | Funeral Director | | 3//-20-9/11 | Sex_ 7. | Age (In yrs, last bii | rthday) Yrs. | If Under Months | 1 Year Days | If Under Hours | Min. | B. Date of Birtl (Month Day)CL.26, | 191 | 9. 5 N | Birthpl Coun VEW | ace (State or Foreign try) Jersey |
| | Maryland -f show | tor | Usual Residence of Decedent 10a. State Mary Land Montgo | omery | 10c. City, Tow ROC | n or Lo KV1. | cation LLE | | | | | | | 10 | Od. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | th with the 23s or 28c | ai Direc | 10e Street and Number 6111 Montrose Ro | oad, #913 | | | 10f. Zip | Code | 2085 | 52 | | ug. Cit Un1 | zen of Wha Led St | t Coun ate | try? |
| 9800 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show amy injury or other traumatic avant, the Medical Exam or must be notified at once. | d by Funer | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Deced Armed Forc Y Yes 2 If Yes, Give Year or Date | es? □ No | ' | Was Deced f Yes, spec 1 ☐ Yes 2 | rify Cubar | spanic Ori n, Mexican Specify: | n, Puerto Ri | ify Yes or No- ican, etc.) | | 14. Race - A Black, \ Specify: | White, e | |
| 21215-0036 | ad within 72 h rgiene. er than "natu t, the Medical | Complete | 15. Decedent's (Specify only highest of Elementary/Secondary (2012) | | - 1 | (Give | tent's Usua kind of wor DO NOT us nant | l Occupa k done d e retired) | ation furing mos | t of working | | | nd of Busin | ess/Ind | lustry |
| Maryland | ould be file Mental Hy arkad oth | To Be (| 17. Father's Name (First, Middle, La Emanuel | I | Halpern | - | | | | Till: | | Ma | rder | | |
| , Mar | and 2 sho ealth and n 27 is m | | 19a Informant's Name/Relationship Elaine R. Parker | (Type, Print) -daughter | | - | | | Way | | Powe Number ille, | | | | |
| Baltimore, | ment of H tant: If Ital jury or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | city) | 20b. Place o cemete King D | avic | i Mem | • Ga. | | | /2005 | Fal: | | irch | , Virginia |
| Ball | permit Depart Import any in | | 21. Signature of Funeral Service Lic | Buzeva | W/ | | | | | | | | ne, PA Le, Ma | aryl | and 20705 |
| | Pnysician /Medical | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) | y one cause on eac a Fil | orous His | tio | | | | | respiratory ari | est, | | | Approximate Interval Between Onset and Death |
| | Examiner | -e- | Sequentially list conditions, if any, leading to immediate | b | as a consequence | | | | | | | | | | |
| , | ficate be executed physician and is the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Einst Underlying Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or | as a consequence | of): | | | | | | | | | · |
| 68760, | ifficate be g physicia as the bur | edicai | | d | | | | | | | | | | | |
| .O. Box | The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | h 2 ☐ Fetal death at at time of death | | Ectopic pro Other (spe | | | | | | 23d. Date of Month | | Y Day Year |
| rds, P | w requires that been signed b should be deta | | Part II. Other significant conditions Chronic Renal Fa | | | | nderlying ca | ause give | in in Part I. | | 23e. Did to | _ | 7 | | e cause of death? |
| al Records, | | Completed by | | | | | | | | | 24a. Was a autops perform | sy | prior | to com | sy findings available pletion of cause of |
| f Vital | Physician: Th this certificate ral director, pag | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes ※ No | Hospital: 1 ☐ Inp | atient 2X ER/OL | utpatien | t 3 🗆 DO | A Othe | | | Check only or | | Other (| Specify |) |
| ion of | ding After fune | | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat | 28a. Date of (Month, | Injury 28b. Day Year) | Time of Injury | M 21 | Bc. Injury Work | at | 28 | d. Describe h | | | | |
| Division | tal or Atters after de al Diracto | Certification: | 3 Suicide 6 Could not 4 Homicide determine | 28e. Place of | Injury - At home, fa , etc. <i>(Specify)</i> | arm, str | eet, factory | , office | | 28 | f. Location (S. City or Tow | treet and n, State | d Number o | r Rural | Route Number, |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical | 29a. Certifylio (Check only one) | Physician: To the b eminer: On the bas and manne | is of examination an | e, death | occurred a restigation, | at the tim- in my op | e, date an inion, dea | d place, an th occurred | at the time, d | ate and | place, and | due to | the cause(s) |
|) | 1 | Σ | 29b. Signature and title of codfield | | | | 290 | License | nymber 49 | 1 | | | signed (M nber 7 | | |
| | 0 | | 30. Name and address of person with Joel Goo. | - | | | - | | ive, | #401 | Bethes | da, | Maryl | and | 20817 |
| : : | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 0 | 2005 32. Ret | jistrar's Signature | F | parts | * | | | | | | | |

| | | | 1 - For State Registrer | State of Maryla | | artment rtificate | | | d Mental Hy | 2 | 005 | 38378 |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------|--------------------|------------------------------|---------------------------------------------|----------------------------|----------------------------------|----------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last, |) | | Timouto | 0, 0, | | 2. Date of D | Reg. No: | | 3. Time of Death |
| | Physici /Medio | | John Hen | ry ‼opl | kins, I | V | | | Novemb | er 4, | 2005 ear | 6:00 P.M |
| | Examir | | 4a. Facility Name (If not institution, give | | | 4b. City, To | wn, or Lo | cation of De | | | ounty of Death | |
| | | | Genesis Nursing & | Rehab. Spa | Creek | Annap | olis | | | A | nne A | rundel |
| | Funeral | | 5. Social Security Number 6. Sec | TAL OFTE | s. last birthday) | If Under 1 Months [| | f Under 24 H Hours M | Irs. 8. Date of B | irth lay, Year) | Cot | nplace (State or Foreign |
| | Director | Į | 215-07-3772 X | 91 | Yrs. | | | | July 2 | , 191 | 4 Mary | rländ |
| | and and | | 10a. State 10b. County | 10c. (| City, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| | Mary 1 sh | Ď | MD Anne Arur | ndel Ar | napolis | - | | | | | | 1 ☐ Yes 2 ☐ No |
| | r 28a | rec | 10e. Street and Number | Idei Ai | паротт. | 10f. Zip C | ode | | | 10g. Citize | on of What Cou | Auntry? |
| | h with | a. | 2135 Sandcastle Co | ourt | | 2140 | 03 | | | Unite | ed Stat | es |
| | be filed within 72 hours after death with the Maryland tal Hygiene do ther than "naturel", or items 23a or 28a-f show event, it a Madical Examinational Leading at event, it a Madical Examinational Leading at the motilised at | Funeral Director | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U.S. 13. | Was Deceder | nt of Hispa | anic Origin? | (Specify Yes or Nuerto Rican, etc.) | | Race - Amer Black, White | ican Indian, |
| õ | or It | | 1 Never Married 2 Married | 1 XYes 2 ☐ No If Yes, Give | 1 | 1 Yes 2 | | Specify: | iono moan, etc.) | | pecity: Whi | |
| 9500-612 | urel', | d by | ¾ XWidowed 4 □ Divorced | Year or Dates: | | | | | | | | |
| | within 72 ene. than "nat | Completed | 15. Decedent's Edu (Specify only highest grad | | (Give | dent's Usual (kind of work of DO NOT use | done duri | ing most of | working | 16b. Kind | of Business/li | ndustry |
| | withi ene. than | E C | Elementary/Secondary (0-12) | College (1-4or 5+) 5+ | 1 | orney | 1611160) | | | Lega | a] | |
| 0 | filed with Hygiene other the | BeC | 17. Father's Name (First, Middle, Last) | J + | | | 18 | B. Mother's N | Name (First, Middle | | | |
| land | lid be i fental i rked o | To B | John Henry Hopkins | s, III | | | Ka | atheri | ne Baile | У | | |
| a | 2 should and Men is marke eumatic | - | 19a. Informant's Name/Relationship (Ty | pe, Print) | 19b. Mailir | ng Address (S | Street and | Number or | Rural Route Numb | er, City or 1 | Town, State, Zi | ip Code) |
| ≥ | 2 5 5 5 | | John K. Hopkins | (son) | 2135 | Sandca | astle | e Ct. | Annapoli | s, Mai | ryland | 21403 |
| or G | - T = 5 | | 20a. Method of Disposition 1 1 Burial 2 ☐ Cremation 3 ☐ F | | Place of Dispo | sition (Name matory or othe | of er place) | Nov | ember 10 | 20c. Loca | ation - City or T | own, State |
| altimor | Pages ment of ent: ff it ury or o | | *4 □ Donation 5 □ Other (Specify) | St. | . Marga: | | | ery 2 | 2005 | Ar | napoli | |
| | permit. Pages Department of I Importent: If ite any injury or o | | 21. Signature of Funeral Service Licens | | | | | | dvent Fune | | | Services |
| מ | ₹0 = # o | | 23a. Part1. Enter the disease, or compl | | | | | | 110 , Annapo | | 21401 | |
| | Physician /Medical Examiner | Examiner | shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | ne cause on each line. | acle ac | Λ | rylt | | | | | Approximate Interval Between Onset and Death |
| Box 68/60, | that the death certificate be executed ed by the attending physician and detached for use as the burial-transit | Physician/Medical Exa | resulting in death) Last | Due to (or as a consect. 3c. If yes, outcome of preg | nancy tal death 3 |]Ectopic preg | | | | 23 | d. Date of deliv | rery Day Year |
| | he de | ysic | 1 Yes 2 No | 4□Pregnant at time of 9□Unknown | death 5L | Other (speci | ify) | | | | | 22, 100. |
| 7. | requires that the een signed by th nould be detache | | Part II. Other significant conditions cor | ntributing to death but not re | sulting in the u | ndertying caus | se given i | n Part I. | 23e. Did | tobacco use | contribute to | the cause of death? |
| g | w requires that s been signed b should be deta | d by | propal | e Ca | | | | | 10 | Yes 2 | No 3□Pro | bably Unknown |
| ecoras | - Q 76 | Completed | | | | | | | 24a. Was | 20 | 24h Ware sub | oney findings available |
| r | has has | шc | | | | | | | - auto | psy ormed? | prior to co death? | opsy findings available ompletion of cause of |
| | icien: Th certificate rector, pag | O | 25. Was case referred to medical | | | | 26 | S Bloop of F | 1 ☐ Yes Death (Check only | 2 No | 1 ☐ Yes | 212 No |
| <u> </u> | | o B | examiner? | lospital: | ☐ ER/Outpatien | it 3□ DOA | Other | | Home 5 Res | | Other (Speci | 60 |
| | ig Phys terthis neraldi | n; T | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | | Injury at Work? | | 28d. Describe | | | (9) |
| <u>ō</u> | Attending ir death. ector; After by the fune | atio | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day rear) | Inquiry | М | | 2 🗆 No | | | | |
| DIVISION | el or Atte s after de il Directo d in by th | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At building, etc. (Spec | home, farm, str cify) | eet, factory, o | office | | 28f. Location (City or To | Street and I wn, State) | Number or Run | al Route Number, |
| | To the Hospitel or Attending Ph within 24 hours atten death. To the Funeral Director, After th completely filled in by the funeral | edical (| 29a. Certifier 1 Certifying Physical Check only 2 Medical Exami | sician: To the best of my kiner: On the basis of examinand manner stated. | nowledge, death nation and/or in | occurred at the vestigation, in | the time, o | date and pla on, death oc | ice, and due to the courred at the time, | cause(s) ar date and pi | nd manner as s ace, and due t | stated. o the cause(s) |
| | To the within 2 To the Complet | Ĕ | 29b. Signature and title of certifier | | | 29c. L | icense nu | ımber | | 29d. Date s | signed (Month, | Day, Year) |
| | | | | | | 7 | DE | 707 | 28 | 11 | -7-09 | 5 |
| | | | 30. Name and address of person who co | mpleted cause of death (Ite | em 23a) (Type, | Print) | | | | | | |
| | | | Haitya Cho | pram.D. | 600R | idal | 4A | ve z | 31 Anna | poli: | SIMI |). 21401 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | nature | 1 | 7 | | | | | |

State of Maryland / Department of Health and Mental Hygiene | 38379 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Hall Anternett 1,2005 November 12:30P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Manor Care Prince George's Largo If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2/7F 218-38-5652 92 Director Aug.11,1913 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28e-f show of other than "natural", or Items 23s or 28e-f shown event, the Modical Extrapret rount be notified at 1 ☐ Yes 2 X No Maryland Anne Arundel Friendship Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6866 Old Solomons Island Road 20758 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Someone Else's Elementary/Secondary (0-12) College (1-4or 5+) Home 8 Domestic h and Mental Hygier 17 is marked other th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If them 27 is marked oth eny injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wesley Contee Joseph Madora 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Friendship, MD Malana Savoy/Daughter 6866 Old Solomons Island 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Cooper's UMC Cem. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11/5/05 Dunkirk, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. Funeral Home Prince Fred.,MD2067 Blader 9. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonan disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** drac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due fo (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (of as a consequence of): sacra attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical venous IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No be detached 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Clostroliu 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6 MD 20062116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7227 A Hanover M. WORKNEM MD 31. Date filed (Month, Day Year) 32. Registra Signature State 2005 Glowar Registrar

| | | | 1- State Registrar | te of Maryland / I | | rtment of H tificate of L | | | giene | 5 3838 | 0 |
|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------|---------------------------------------------|------------------------------------------|--------------------|---------------------------------------|------------------------------------------|----------------|
| | | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | ath | 3. Time of D |)eath |
| | Physicia /Medic | | Richard Lee | Herbe: | r, | Sr. | | Novembe | | 99ar 05 2:50 | a ^M |
| | Examin | _ | 4a. Facility Name (If not institution, give street as | nd number) | | 4b. City, Town, or | Location of Death | | 4c. County of | of Death | |
| | | | Chesapeake Hospice Ho | ouse | | Linthic | | | Anne | Arundel | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last bit | ** | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | (Month, Da) | y, Year) | Birthplace (State or Country) | Foreign |
| > | Director | | Usual Residence of Decedent | 71 | Yrs. | | | Sep 14 | , 1934 | Iowa | |
| | land ow | Ì | 10a. State 10b. County | 10c. City, Tow | vn or Loc | ation | | | | 10d. Inside City | Limits |
| | Mary -f ah | tor | MD Anne Arunde | 1 | | Glen Bu | rnie | | | 1 ☐ Yes 2 | 2 🔀 No |
| | r 28a | Director | 10e. Street and Number | | | 10f. Zip Code | <u> </u> | | 10g. Citizen of W | hat Country? | |
| | death with the Maryland ma 23a or 28a-f ahow ritteat be coeffiled at | | 332 Highland Drive, A | ot. 102 | | 2 | 1061 | | US | Δ | |
| | deat | Funeral | 11. Marital Status 12. Was | s Decedent Ever in U.S. ed Forces? | 13. W | /as Decedent of His Yes, specify Cubar | | pecify Yes or No- | | - American Indian, | |
| 36 | d within 72 hours after death with the Marylan jiene. r than "naturel", or ftame 23a or 28a-f ahow | by Fu | 1 □ Never Married 2 □ Married 1 □ | Yes 2X No es, Give r or Dates: | | Yes, specify Cubar | | Hican, etc.) | Specify: | k, White, etc. | |
| 1215-0036 | 2 hou | | 15. Decedent's Education | 16a | ı. Decede | ent's Usual Occupa | tion | | 16b. Kind of Bus | white | |
| 2 | within 72 ene. than "nai | Completed | (Specify only highest grade complete Elementary/Secondary (0-12) Coll | ege (1-4or 5+) | (Give k life. D | rind of work done d O NOT use retired, | uring most of worl | king | | , | |
| N | d with | EO | Listing iteration (c. 12) | | ales | represen | tative | | compu | iter | |
| 2 | I be filed ntal Hygi od other event, I | Be (| 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | ne (First, Middle, | Maiden Sumame | 9) | |
| Maryiand | Ment Ment mrkec | 2 | Arnold Joseph 1 | Herber | | | Eunice | Marie | e Blo | dgett | |
| <u>a</u> | 2 sho and le m | | 19a. Informant's Name/Relationship (Type, Prin | 19t) | b. Mailing | Address (Street a | nd Number or Ru | ral Route Numbe | er, City or Town, S | State, Zip Code) | |
| a) S | l and lealth m 27 her tu | | Barbara Herber, former | | | | | | | , MD 20772 | |
| Baltimore, | ges it of H | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) | | ery, crem | ition (Name of atory or other place | 9) | Date | 20c. Location - (| City or Town, State | |
| ======================================= | t. Pa rtmen rtant: njury | | | Metrop | | tan Crema | | -08-05 | Alexand | lria, VA | |
| E E | permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic es once. | | 21. Signature of Funeral Service Licensee | Grow | | Name and Addres | , | ne, P.A. | , Owings | , MD 2073 | 6 |
| | | | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus- | that caused the death. Do | | | | | | Approximate Interval Between | |
| | Physician | | Immediate Cause (Final disease or condition | Cardiomyopath | ıv | | | | | Onset and De | ath |
| | /Medical Examiner | | resulting in death) | ue to (or as a consequence | _ | | | | | | |
| | LAUITINIE | _ | | Chronic Ethar | | Dependenc | e and Ab | ouse | | | |
| | nsit | ine | if any, leading to immediate D cause. Enter Underlying Cause (Disease or injury | ue to (or as a consequence | ot): | | | | | | |
| | xecut and al-trar | Examiner | that initiated events c. | ue to (or as a consequence | of); | | | | | | |
| 09/89 | ificate be executed g physician and as the burial-transit | | | · | , | | | | | | |
| 89 | - 00 | edicai | 0. | | | | | | | | |
| ŏ | | Physician/M | | s, outcome of pregnancy | | | | | 23d. Date | of delivery | |
| n | 0 0 0 | icia | in the past 12 months? | Live birth 2 Fetal death Pregnant at time of death | | Ectopic pregnancy Other (specify) | | | Mon | th Day Ye | ar |
| J. | requires that the de: een signed by the a hould be detached f | hys | 9 Unknown | Unknown | | | | | | | |
| ś | es thg gned be de | by F | Part II. Other significant conditions contributing | g to death but not resulting i | in the un | derlying cause give | n in Part I. | 23e. Did to | obacco use contri | bute to the cause of dea | ath? |
| ecord | w require been signature | ted | dementia | | | | | 1 X □ Y | ′es 2□No | 3 ☐ Probably 4 ☐Un | known |
| င္ပ | > D 0 | pie | | | | | | 24a. Was | | ere autopsy findings av | allable |
| Ĭ | The lav | Completed | | | | | | perio | rmed? de | eath? | 130 01 |
| Vital | Physician: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | | | | 26. Place of Dea | th (Check only o | ne) | | |
| 0 | Physi this c al din | ² | 1 ☐ Yes 2 No Hospital: | 1 Inpatient 2 EH/O | | | 4 🗆 Nuising H | | | r (Specify)Hospic | æ |
| | ing After une | lon | 1 XNatural 5 ☐ Pending | | Time of Injury | 28c. Injury Work | | 28d. Describe h | now injury occurre | d House | |
| <u> </u> | Attending or death. ector: After by the fune | icat | 2 Accident investigation 3 Suicide 6 Could not be | Place of Injury - At home, fa | arm etro | | es 2 □ No | 28f Location /5 | Strant and Numbo | r or Rural Route Numbe | |
| DIVISION | F 9 F C | Certification: | 4 Homicide determined 206. | building, etc. (Specify) | aiii, stie | et, factory, office | | City or Tow | m, State) | r or murai moute ivumbe | #1, |
| | To the Hospital of within 24 hours af To the Funeral Completely filled in | Medical (| 29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: On and | the basis of examination ar | e, death | occurred at the tim estigation, in my op | e, date and place, inion, death occur | and due to the or | cause(s) and mar date and place, a | ner as stated. nd due to the cause(s) | |
| | o the | Me | 29b. Signature and title of certifier | I manner stated. | 1 | 29c. License | number | | 29d. Date signed | (Month, Day, Year) | |
| ı | F s ⊢ ŏ | | 1 85. B P P | 100000 | MI | D 436 | 23 | | 11/07 | | |
| | | | 30. Name and address of person who completes | d cause of death (Item 23a) | (Туре. F | | | | , 0 / , | | |
| | 4 | | Erik L. Russell, M.D. | | | | Sto. A. | Glen B | ırnie M | D 21061 | |
| 199 | Sta | te | 21 Date filed (Month Day Vees) | 20 Decistre Cionetura | | • | - JUCT | | | | |
| 200 | Registr | ar | NOV 0 8 20 | 105) Senevar | Jr. | Coarles | | | | | |

| | | • | State of Maryland / Department of Healt 1- State Registrar Amend Item 26 per verb., G851, 01.12/06dhb | | | 38381 |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) | 2. Date of De Month NOV | ath 17 ^{Pay} 2 00 5 | 3. Time of Death |
| | /Medic | al | Marjorie Louise Hamîll 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locati | | 4c. County of Dea | 10:20 a M |
| | Examin | er | Garrett Co. Memorial Hospital Oakland | | Garrett | |
| | Funeral Director | | 5. Social Security Number 216 38 1735 6. Sex 1 | nder 24 Hrs. 8. Date of Bir urs Min. (Month, Da Jan 1 | ly, Year) Co | thplace (State or Foreign buntry) aryland |
| | /land low | } | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. In side City Limits |
| | e Mar | Director | MD Garrett Oakland | | | 1 XYes 2 No |
| | with th | Dire | 10e. Street and Number 10f. Zip Code 21550 | | 10g. Citizen of What Co | ountry? |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, Ite Medical Exertifier must be notified at once. | by Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No If Yes, Other | xican, Puerto Rican, etc.) | 14. Race - Ame Black, Whit | |
| 21215-0036 | thin 72 hours e. en *natural Medical E | Completed t | 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) | most of working | 16b. Kind of Business | /Industry |
| 7 | ygien ygien her th | | 12 4 School Teacher | Nother's Name (First, Middle | Education Maiden Sumame | |
| Maryland | d be fil antal H ed oth |) Be | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | largaret Merr | | |
| aryl | should nd Me mark umatic | Ţ | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and NL | umber or Rural Route Numb | er, City or Town, State, | Zip Code) |
| ž | and 2 salth a n 27 is | | Elizabeth Hart 701 Red Oak Circ | | | 21550 |
| ore | ges 1 t of He If iten or oth | | 20a. Method of Disposition 1 \overline{\text{Burial 2 \subseteq Cremation 3 \subseteq Removal from State}} 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem Grd | Date | 20c. Location - City or Oakland, M | |
| Baltimore, | it. Pa trtmen ortant: njury t. | | . 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee / 22. Name and Address of F | Tara 100 | | D |
| Ba | Depa Impo any ir | | MaridA. Dindock 21 N. 2nd S | Buldock-i | _ | |
| | Physician | | 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Acute renal failure resulting in death) | h as cardiac or respiratory a | rrest, | Approximate Interval Between Onset and Death |
| Н | /Medical Examiner | | Due to (or as a consequence of): Sequentially list conditions Acute bronchitis | | | 1 week |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter third-pring Cause (Disease or injury bases of injury cause (Disease or injury) | | | 1 week |
| 8760, | death certificate be executed e attending physician and of for use as the burial-transit | Ical Examiner | Cause (Disease or injury that initiated events resulting in death) Last C. Con_estive ulmonary Due to (or as a consequence of): | edema | | 1 week |
| 9 | rtificating phy | | IF FEMALE: | | | |
| .O. Box | | Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | | 23d. Date of de Month | livery Day Year |
| Δ. | uires that signed b | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F COPD | | tobacco u <i>s</i> e contribute t Yes 2 ¼√ io 3 ☐ P | o the cause of death? |
| Řecords, | The law requires that the zate has been signed by th page 2 should be detache | ompleted | Chronic renal failure | 24a. Was auto perfo 1 Yes | psy prior to death? | utopsy findings available completion of cause of |
| /ita | | BeC | examiner? | Place of Death (Check only | one) | |
| ốn ối Vital | Phys rthis ral di | tlon; To | 27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 ☑ Year | | dence 6 Other (Spe how injury occurred | ocify) |
| DIVISION | al or Attending after death. I Director: After d in by the fune | Certification; | 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (City or To | Street and Number or R wn, State) | ural Route Number, |
| | To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the | Medical C | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, dat one in the basis of examination and/or investigation, in my opinion, and manner stated. | te and place, and due to the , death occurred at the time, | cause(s) and manner a date and place, and du | s stated. e to the cause(s) |
| | To th within To th comp | Me | 29b. Signature and talk of certifier 29c. License numi | | 29d. Date signed (Mon. | th, Day, Year) |
| | , | | Mefany D4246 | 64 | 11/17/05 | |
| | 6 | | 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Sotiere Savopoulos M.D. 2008 Md. Hwy. Mt. Lake | e Park, MD 2 | 1550 | |
| | Sta Regist | | 31. Date filed (Month, Day, Year) NOV 1 8 2005 32. Registrar's Signature | | | |

| | | | For Stata Registrar | State | of Mar | • | | ment o | | | Mental H | ygiene Reg. No | C U U 2 | 38382 |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------|------------------------|-----------------------|-----------------------------|-----------------------|---------------------------------|--------------------------------|---------------------------|------------------------------------------------|-----------------------------------------------------|
| | | | Decedent's Name (First, Middle, La | st) | | | | | | | 2. Date of I | Death | | 3. Time of Death |
| | Physicia | | ALLAN | | | | HA | RRIS | | | NOVEM | Da IBER | y Year 8, 2005 | 18:43 M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | e street and n | umber) | | 41 | b. City, Tow | n, or Loc | ation of Deat | | | County of Deat | h |
| | | | SUBURBAN HOSPITA | | | | | | | THESDA | | | | TGOMERY |
| | Funeral | | 5. Social Security Number 6. 5 | Sex IS≵M 2∐ F | 7. Age (| 'In yrs. last bir | | Under 1 You | | Jnder 24 Hrs ours Min. | (Month, | Birth Day, Year, | 9. Birt | hplace (State or Foreign nuntry) |
| | Director | } | 578-26-4339 Usual Residence of Decedent | | | 79 | TIS. | | | | 11/11/ | 1925 | PENI | NSYLVANIA |
| | land ow | | 10a. State 10b. County | | 1 | Oc. City, Tow | n or Locati | ion | | | | | | 10d. Inside City Limits |
| | Mary -feh | ţ | MARYLAND MONTGO | MERY | | | | ROCK | VILL | E | | , | | 1∭ Yes 2 No |
| | death with the Maryland me 23a or 28e-f ehow rimal be routhed at | Director | 10e. Street and Number | | | | | 10f. Zip Cod | de | | | 10g. Ci | tizen of What Co | ountry? |
| | th wil | | 12111 HITCHING PO | OST LAN | E | | | | | 2085 | 2 | | U.S.A | Α. |
| | r dea | Funeral | 11. Marital Status | 12. Was De Armed F | Forces? | | 13. Was | s Decedent es, specify (| of Hispar Cuban, M | nic Origin? (S lexican, Puer | specify Yes or to Rican, etc.) | No- | Race - Ame Black, Whit | |
| 5 | y within 72 hours after death with the Marylan plane than * naturel; or Iteme 23a or 28e-f show the Medical Exardinar must be notified at | by Fi | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ⊠Yes If Yes, G Year or | 2 [] No Sive | WWII | 1 🗆 | Yes 2∑ | No S | oecify: | | | Specify: | WHITE |
| 215-003b | ture! | edt | 15. Decedent's E | | Dates. | 16a. | . Deceden | t's Usual O | cupation | | | 16b. H | (ind of Business | Industry |
| <u>.</u> | within 72 ene. then ne | plet | (Specify only highest gr Elementary/Secondary (0-12) | ade completed | (1-4or 5+) | | (Give kin life. DO | d of work do NOT use re | one durin stired) | g most of wo | rking | | | |
| 717 | d with giene ar the | Completed | Elementary/Secondary (0-12) | 2 | | | SALE | S REP | • | | | | FURN | NITURE |
| <u> </u> | be filed tal Hygi d other | Be (| 17. Father's Name (First, Middle, Las. |) | | | | | | | me (First, Midd | | n Surname) | |
| ylan | D & 0 0 | L _o | JOSEPH FEINBERG | | | | | | | | TTE PEI | | | |
| <u>a</u> | s 1 end 2 shou I Health and M Item 27 Is mar other treumat | | 19a. Informant's Name/Relationship ELAINE L. HARRIS | | | | • | | | | | | or Town, State, I LLE, MD | |
| | Health | 1 | 20a. Method of Disposition | WILL | | 20b. Place of | f Disposition | on (Name o | of | TODI D | Date . | | ocation - City or | |
| ٥ | 00 | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Cont | | n State | | | ory`or other MEMO | | d 11/ | 11/2005 | FAT. | LS CHIIRO | CH, VIRGINIA |
| Baltimore, | | | 21. Signature of Funeral Service Lice | | | KING I | | | | - | | | HAPELS, | |
| n | permit. Departr Importe eny infl | | Donald C. | Sta | tile | much | DAN 117 | ZANSK O ROC | Y-GO KVIL | LDBEKG LE PIK | E ROCK | AL C | HAPELS, E, MARYI | LAND 20852 |
| | | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | plications that | t caused the | ne de th. Do | not enter t | he mode of | dying, sı | uch as cardia | c or respiratory | arrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | | OCARDIA | | | | | | | | Onset and Death 1 HOUR |
| | /Medical | | resulting in death) | | | consequence | | TIMOI | 1011 | | | | | 2,110011 |
| н | Examiner | | Sequentially list conditions, | | | CLEROT | | RDIOV. | ASCU | LAR DI | SEASE | | | 25 YEARS |
| | ed sit | ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | o (or as a | consequence | of): | | | | | | | |
| | be executed icien and burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to | o (or as a | consequence | of): | | | | | | | |
| 8760 | icate be executed physicien and s the burial-transit | dicai E | | | | | | | | | | | | |
| 68 | ificate g physi as the | edic | | u. | | | | | | | | | | |
| Box | death certific e ettending p od for use as f | by Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, c | | pregnancy Fetal death | 3 []Ec | topic pregn | ancv | | | | 23d. Date of de | |
| | 0 0 | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | | gnant at ti | me of death | | ther (specif | | | | - | Month | Day Year |
| o. | at the de by the stached | بخ | 9 Unknown | | | | | | | | 00. 0 | 4111 | | the course of death? |
| | The law requires that the ate hes been signed by th page 2 should be detache | | Part II. Other significant conditions AORTT | contributing to C STENC | | not resulting i | in the unde | erlying caus | e given ir | Part I. | 1 | o tobacco TYes 2 | | o the cause of death? |
| 0 | w require been sign | eted | | | DID | | | | | | | | | |
| Vital Records, | e law hes t | Completed | DIABETES MELLITI RENAL FAILURE | S | | | | | . | | 24a. W | as an topsy normed? | prior to death? | utopsy findings available completion of cause of |
| a | icien: The l certificate he rector, page | | | | | | | | | | 1 Yes | 2 ∑ N | | 2 □ No |
| Ĭ | ysicien: is certific director, | o Be | 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No | Hospital: |] Inpatient | 2 X ER/O≀ | utnationt | 3[] DOA | Other | | ath (Check on) | | 6 Other (Spe | outil. |
| Division of | £ £ = | 7: To | 27. Manner of Death | 28a. Dat | e of Injury | 28b. | Time of | | Injury at Work? | 4 🗀 INDI SINI 9 | 28d. Describ | | | City) |
| <u></u> | nding ath. r: Afte e fun | aţio | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigate | | onth, Day | rear) | Injury | М | | 2 🗌 No | | | | |
| N N | I or Attending Patter death. Director: After it in by the funera | Certification: | 3 Suicide 6 Could not determined | 288. Pla | ce of Injur | y - At home, fa | arm, street | , factory, of | fice | | | (Street a | | ural Route Number, |
| ā | 0 = 5 = | Cer | | | | | | | | | | | | |
| | Hosp 14 hou Fune felly fill | icai | 29a. Certifier 1 Certifying P | miner: On the | basis of e | xamination ar | | | | | | | | |
| | To the Hospital or within 24 hours after To the Funerel Direction completely filled in I | Medical | one) 29b. Signature and the Certifier | and ma | anner state | au. | | 29c. Li | cense nu | mber | | 29d. D | ate signed (Mont | h, Day, Year) |
|) | F ¥ F 8 | | Marie | 7 | . // | | 40 | | D1 | 3818 | | 1 | EMBER 9 | |
| | | | 30. Name and address of person who | completed ca | use of dea | ath (Item 23a) | (Type, Pri | int) | | | | 1 | | |
| | 20 | | GARY FISHER, MD | 5530 W | VISCO: | NSIN AV | VE #7 | 30, C | HEVY | CHASE | , MD 20 | 815 | | |
| | Sta | | 31. Date filed (Month Day, Year) | 2005 32. | gistrar | 's Signature | A. | 1000 | | | | | | |
| 1 | Regist | rar | NUV 14 | 2005 | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | V D | 0000 | | | | | | | |

18.43

Harris, Allan

State of Maryland / Department of Health and Mental Hygiene Reg. No.U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month HANG NOV. 8:29 A M MACY 10, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

MARCH 12,1928 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Director 474-39-6750 77 CAMBODIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23e or 28e-1 show any jury or other traumatic event, the Madical Examinar must be notified an once. 1 Yes 2 No Directo MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1404 MULLINS ST. 20904 CAMBODIA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced CAMBODIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 6 AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 TEP HANG SOURNG SAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOKUNTHEARY CHHOR/DAUGHTER 1404 MULLINS ST., SILVER SPRING, MD. 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS_CREMATORY | 11-19-2005 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mysceschel Acute **Physician** /Medical Due to (or as a consequence of): Examiner Cardiogenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) the di 9 Unknown signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Tes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 PNo 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a
To the Funeral C
completely filled i Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 47655 NOVEMBER 10, 2005 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAPLE AVE. TAKOMA PARK, Md. 20912 7901 LAURENCE KELLEY egistrar's Signature 31. Date filed (Month. State Registrar

| | | | 1 - For State of Ma | ryland / Depa <i>Cei</i> | artment of He | | | ene 2005 | 38384 |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------|------------------------------------|-----------------------------------------------|-------------------------------------------|------------------------------------------------------|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Charles Elwaco | Hes | S | | 2. Date of Death Morth | 1 ZOC | 3. Time of Death 5 0930 M |
| | Examir | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or L | ocation of Dea | ath | 4c. County of De | eath |
| | | \$ | COASTAL HOSPICE @ THE LAKE | | | SBURY | | | OMICO |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age 191–18–2508 12 F 7. Age | (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | Hours Mi | n. (Month, Dav.) | Year) 9. E | Birthplace (State or Foreign Country) |
| | Director | | Usual Residence of Decedent | 113. | | | NOV. 2, | 1926 P | ENNŚYLVANIA |
| | land ow | | | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | Man Fr sh | to | MARYLAND WORCESTER | | OCEAN | CITY | | | 1 ☐ Yes 2 ☐ No |
| | r 28c | Director | 10e. Street and Number | | 10f. Zip Code | 0111 | 10 | g. Citizen of What | |
| | 23e C | aiD | 12024 OCEAN GATEWAY LOT#3 | | 218 | 342 | | U. | S.A. |
| | dea | Funerai | 11. Marital Status 12. Was Decedent E- Armed Forces? | ver in U.S. 13. | Was Decedent of Hist If Yes, specify Cuban, | panic Origin? (| Specify Yes or No- | | nerican Indian, |
| 9 | or It | y Fu | 1 Never Married 2 Married 1 Wes 2 No | | | Specify: | rio riioari, etc.) | Specify: | |
| 8 | 72 hours after death with the Maryland "netural", or Items 23e or 28e-f show rates! Exercises the notified at | d by | 3 Widowed 4 Divorced Year or Dates: | Jnk. | | | | | WHITE |
| 21215-0036 | _ = | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give | dent's Usual Occupati kind of work done du DO NOT use retired) | ion ring most of w | orking | 6b. Kind of Busines | ss/Industry |
| 72 | with sne. | duo | Elementary/Secondary (0-12) College (1-4or 5+ |) | ADMINIS | STRATOR | | RAT | LROAD |
| b | othe ant, | Be C | 17. Father's Name (First, Middle, Last) | | | | ame (First, Middle, Ma | | |
| ylar | 2 should be and Mental is marked of aumatic ava | To B | MILTON HESS | | | EDITH | WILES | | |
| , Maryland | E # K I | | 19a. Informant's Name/Relationship (Type, Print) MARGERY N. HESS, WIFE | 19b. Mailin 120 | ng Address (Street an 124 OCEAN (| d Number or F GATEWAY | LOT#3, OC | City or Town, State CEAN CITY | , Zip Code) , MD 21842 |
| Baltimore, | 0 0 | | 20a. Method of Disposition 1 | 1 | esition (Name of matory or other place) N CEMETERY | | | Oc. Location - City of | or Town, State |
| Balti | permit. Page Department Important: It any injury o | | 21. Sign, ure of Fureral Service Ricensee | | 2. Name and Address | of Facility | | NATIONA | L PIKE |
| | | | 23a. Part 1 Enter the disease of complications that caused t | he death. Do not ente | | | | | Approximate |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | tastite | Colon | Can | cer | | Interval Between Onset and Death |
| | Examiner | | | consequence of): | | | | | |
| | p ii | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | consequence of): | | | | | |
| | death certificate be executed the attending physician and ad for use as the burial-transit | Examine | that initiated events | consequence of): | | | | | |
| 8760, | cate be ex physician the buria | dicai E | d | | | | | | |
| 9 | titical ng phy as th | Medi | | | | | | | |
| Вох | eath certition attending p | an/\ | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 | | Ectopic pregnancy | | | 23d. Date of d | |
| 0. | the dea y the at ached to | Physician/Me | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown | me of death 5 | Other (specify) | | | Month | Day Year |
| Q | that ed b deta | | Part II. Dther significant conditions contributing to death but | not resulting in the ur | nderlying cause given | in Part I. | 23e. Did toba | cco use contribute | to the cause of death? |
| ecords, | w requires been sign should be | ed by | | | | | 1 ☐ Yes | 2 No 3□F | Probably 4 Unknown |
| lecc | aw as b | Completed | | | | | 24a. Was an autopsy | prior to | autopsy findings available completion of cause of |
| E E | | S | | | | | performe 1 ☐ Yes 2 | death? SNo 1 ☐ Ye | |
| Vital | Physician: Th this certiticate ral director, pag | Be | 25. Was case referred to medical examiner? | | Other | | eath (Check only one) | | |
| o | Phys r this ral di | - To | 1 195 20 1 1 Sunpatient | | 3000 | 4 Nursing | Home 5 Residence | | ecify) |
| 0 | ding It. th. Atter funer | tion | 27. Manner of Death Natural 5 Pending Accident investigation 28a. Date of Injury (Month, Day) | Year) Injury | Work? | s 2 □No | 200. 200.00 110.0 | injury obtained | |
| Division | I or Attanding after death. Diractor: Atter | ifica | 3 Suicide 6 Could not be | y - At home, farm, stre | eet, factory, office | | 28f. Location (Stree | et and Number or F | Rural Route Number, |
| á | s after s after al Dira | Certification: | 4 Homicide determined building, etc. | (Specify) | | | City or Town, | State) | |
| | To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral | edical (| 29a. Certifier (Check only one) / Certifying Physician: To the best of Examiner: On the basis of early manney state | xamination and/or inv | occurred at the time, vestigation, in my opin | , date and plac lion, death occ | e, and due to the causurred at the time, date | se(s) and manner a a and place, and du | as stated. se to the cause(s) |
| | y To the within 2. To the I | Me | 29b. Signature and title of certifier | 10.0 | 29c. License n | number | 290 | . Date signed (Mor | nth, Day, Year) |
| 1 | 12 IVA | | · WYELK | /W/ | Ua | 1621 | 5 | 11-11-0 | 15 |
| | 10+1 | | 30. Name and address of berson who completed cause of dea | Coast Hos | Sper Po | box 1 | 1733 Sa | lisky, | MD 21802 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 5 2005 | s Signature | citi | | | /′ | |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Cynthia Ann Staubs Hackett November 9 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Broadmore Assisted Living Hagerstown Wahsington County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F 83 Yrs. Director 215-20-6794 1921 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehow item 27 ie marked other than "naturel", or items 23a or 28a-f ebov other traumatic event, the Mcdical Examinar must be notified at XX Yes 2 □ No Maryland Directo Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1175 Professional Court 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene.
7 ie marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Waitress Resturant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Don Arbogast Icy Teter Arbogast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 ie Rhonda Lee Teter 956 Mulberry Ave. Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
important: if ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hill Crest Mem. Park | 11-13-05 | Cumberland Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart adure. List only one cause on each line. Immediate Cause (Pinal disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or Examine use as the burial-transit 181054 that initiated events resulting in death) Last the attending physician P.O. Box 68760 death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown à ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: ASSISTED 1 Tes 2 ST No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Mother (Specify) LIVING 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl
 24 hours after death.
 Funerel Director: After to Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the I 29c. License number 29d. Date signed (Month, Day, Year) 23815 J6H-20 State Registrar

| • | | 1 | For State Registrer | State of Maryla | | artment of Health | | ital Hygier | | 38386 |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------|---------------------------------------------------------|------------------------------------------|--------------------------|------------------------------|--------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, L. | est) | | | | Date of Death Month D | ay Year | 3. Time of Death |
| | Physicia /Medic | | JIAN | RONG | HUANG | | _ | lov. 4, | 2005 | 8:35 P M |
| | Examin | - | 4a. Facility Name (If not institution, gi | | | 4b. City, Town, or Location | | 4 | lc. County of Dea | |
| | | | Randolph Hill | | | Silver S | - | Date of Birth | Montgo | mery thplace (State or Foreign |
| | Funeral | | o. Good, Good Ny | 157M 2□ E | rs. last birthday) Yrs. | Months Days Hour | rs Min. | Month, Day, Yea | ir) Co | nipiace (State of Poreign nuntry) |
| | Director | - | 230-79-0876 Usual Residence of Decedent | 69 | | | <i>E</i> | lug.5,1 | 930 CI | IIIa |
| | land | | 10a. State 10b. County | 10c. | City, Town or Le | ocation | | | | 10d. Inside City Limits |
| | Many -fsh | ţō | MD Monto | omery | Silv | er Spring | | | | 1 ∑XYes 2 ☐ No |
| | or 286 | rec | 10e. Street and Number | | | 10f. Zip Code | | 10g. (| Citizen of What Co | ountry? |
| | th wit | Funeral Director | 3602 Deland | | | 2090 | | | U.S.A | |
| | eems erms | ner | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | 1 U.S. 13. | Was Decedent of Hispanic If Yes, specify Cuban, Mexi | : Origin? (Specify cican, Puerto Rica | Yes or No- an, etc.) | 14. Race - Ame Black, Whi | |
| 36 | or le | by Fu | 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☑ No Spec | cify: | | Specify: V | Mhite |
| 21215-0036 | in 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show "natural", or Items 23e or 28e-f show | ed b | 15. Decedent's | | 16a. Dece | dent's Usual Occupation | | 16b. | Kind of Business | /Industry |
| 5 | - 1 39 | plet | (Specify only highest g | rade completed) College (1-4or 5+) | (Give | kind of work done during n DO NOT use retired) | most of working | | | |
| 212 | d within giene. rr then " | Completed | Elementary/Secondary (0-12) 5th | College (17401 54) | C] | nef | | | Restaur | ant |
| פַ | ₩ ¥ ₩ ± | Be C | 17. Father's Name (First, Middle, Las | | | 18. Mo | | irst, Middle, Maid | | |
| <u>lar</u> | should be f nd Mental I marked of umatic eve | Tof | Zhao Hin | Huang | | | | Li She | | |
| Maryland | 0. 00 00 00 | | 19a. Informant's Name/Relationship | (Type, Print) | | ng Address (Street and Nu | | | | |
| | 1 and 2 Health tem 27 l | | Hui Juan Kuan | g- Wife | | 2 Delano St | t Silve | r Spri | ng MD Location - City or | 20902 Town State |
| O. | Tite | | 20a. Method of Disposition 1 🗆 Burial 2 🖫 Cremation 3 | ☐Removal from State | cemetery, cre | matory or other place) | | | _ | |
| Baltimore, | tmen tant: | | ' 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice | | | Fnr SVCS 2. Name and Address of Fa | 11/13/ | | lexandı neral F | |
| Bal | permit. Pages 1 Department of H Important: If ite any injury or ot | | 21. Sonatury of Funeral Service Lic | Sichert | 11 | | | | | Le, MD20850 |
| | | | 23a. Part1. Enter the disease, or co shock, or heart laiture. List on | mplications that caused the d | leath. Do not en | ter the mode of dying, such | h as cardiac or re | spiratory arrest, | | Approximate Interval Between |
| | · | | Immediate Cause (Final | | | | | | | Onset and Death |
| | Pnysician /Medical | | disease or condition resulting in death) | a. LUNG Due to (or as a con: | CANCE sequence of): | 8 | | | | |
| | Examiner | | | h | | | | | | |
| | D = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cons | sequence of): | | | | | |
| | ecuted and trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | coguence of): | | | | | |
| 8760, | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit | Ð | resulting in doubly East | Due to (or as a con- | sequence or). | | | | | |
| 87 | cate b physic | Physician/Medical | | d | | | | | | |
| 9 X | death certifica attending ph | /Me | IF FEMALE: | 23c. If yes, outcome of pre | | | | | 23d. Date of de | livery |
| Вох | atter I for u | ciar | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time | | □Ectopic pregnancy □ Other (specify) | | | Month | Day Year |
| P.O. | that the de ed by the detached | ysi | 9 Unknown | 9□ Unknown | | | | | | |
| | es that igned b | by Pl | Part II. Other significent conditions | | resulting in the | underlying cause given in P | Part I. | | | o the cause of death? |
| rds | v requires been sign should be | be | HYPERTENSI | JN | | | | 1 💢 Yes | 2 □ No 3 □ F | robably 4 Dunknown |
| ၀ | aw requ | Completed | | | | | | 24a. Was an autopsy | 24b. Were a | utopsy findings available completion of cause of |
| R | The lav | Eo | | | | | | performed 1 ☐ Yes 2 🔀 | ? death? | s 2 ⊡ No |
| ita | icien: Th certificate rector, pag | BeC | 25. Was case referred to medical examiner? | | | | Place of Death C | check onl one | | |
| of Vital Records, | Physicien: r this certific ral director, | ို | 1 ☐ Yes 2 🔀 No | | 2 ER/Outpatie | | | | 6 □Other (Sp | ecify) |
| u u | ding P h. After t | | 27. Manner of Death 1 XNatural 5 ☐ Pending | 28a. Date of Injury (Month, Day Yea | r) 28b. Time Injury | of 28c. Injury at Work? M 1 □ Yes | | I. Describe how it | ijury occurred | |
| sio | Attending r death. Sector: After by the fune | cati | 2 Accident investiga 3 Suicide 6 Could no | | At home farm s | | | Location (Street | and Number or F | Rural Route Number, |
| Division | or At after of Direct in by | Certification: | 4 Homicide determin | building, etc. (Sp | pecify) | troot, ractory, diffee | | City or Town, S | tate) | |
| | spitel ours neret filled | 2 | 29a. Certifier 1 | Physician: To the best of my | knowledge, dea | ith occurred at the time, dat | te and place, and | due to the cause | e(s) and manner a | is stated. |
| | To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page | edical | (Check only 2 Medical Ex | eminer: On the basis of exar and manner stated. | mination and/or | nvestigation, in my opinion, | , death occurred | at the time, date | and place, and du | e to the cause(s) |
| | To th within To th comp | Me | 29b. Signature and title of certifier | | | 29c. License num | | 29d. | Date signed (Mor | |
| | | | Hous | re setter | ng | D5669 | 1 | | Novembe | er 8, 2005 |
| | 1 | | 30. Name and address of person w | | | | | | | |
| | 1 | | Ghousia Sult | ana, MD 121 | | itage Park | Cir S | ilverSr | ring, l | MD 20906 |
| | St Regist | ate trar | 31. Date filed (Month, Day, Year) | 9 2005 32. Hegistrar's S | 1.65 | Sporte . | | | | |

State of Maryland / Department of Health and Mental Hygien 🕒 🛭 🖯 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 13 2005 CLARA JANE HARDEN 3:30AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL GARDENS EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT 10 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 1 F Months Days Yrs. MARYLAND 89 1916 215-26-2769 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Modical Exactinar toust be notified at 1 XYes 2 □ No Director MD TALBOT EASTON 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 545 CYNWOOD DRIVE 21601 or Items 23a USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2 Yes, Give 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE Specify: þ 3 XWidowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene Important: If item 27 ia marked other than "I any injury or other traumatic event, Ite Man Elementary/Secondary (0-12) College (1-4or 5+) 12 REGISTERED NURSE HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROGER ATWOOD MILES ARITHINIA STEVENSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS J. HALL/DAUGHTER 2007 MORNING TIDE LANE, LEAGUE CITY, TEXAS 77573 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 11/14/2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 NOHA R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CN diovasular Dispase ATHEROSCIEVOTIC 14691 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) attending physician Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by eq 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page certificate 20 No 1 ☐ Yes 2 1 No 1 TYas Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 45XSTING examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA LIVING this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide after within 24 hours a To the Funeral 6 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31466 TILES 30. Name and address of person and complete and use of death (Item 2 a) (Type, Print) LUDWIG J./EGLSEDER/III M.D. 503 IDLEWILD AVE EASTON, MD 21601 31. Date filed NOV Day, 5a 2005 Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygie \mathfrak{p} 0Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** NOVEMBER 13 2005 ELMA V. HARRINGTON 3:40AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29262 HEWORTH ROAD EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG 26 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 89 MARYEAND 212-16-1497 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or itama 23e or 28e-f shov traumatic event, the Medical Everth at must be notified at 1 Yes 2 ☐ No Directo MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29262 HEWORTH ROAD 21601 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If itam 27 is marked other that eny injury or other traumatic evant. It is an 2006. CIVIL SERVICE U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAWRENCE E. LEGATES IDA VIOLA WILLIAMSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA HARPER/NIECE 3400 POPLAR NECK ROAD, PRESTON, MD 21655 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2005 PRESTON, MARYLAND JUNIOR ORDER CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostrowski C.F.S.P. Joseph 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a consequence of):

Care 6 provide for accident Immediate Cause (Final disease or condition resulting in death) Myocardial Pnysician /Medical **Examiner** 2 menth Sequentially list conditions, any, bearing to infinite unate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 2 No 1 TYes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alya 00051132 11-14.55 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10) JORGE H. ABREGO M.D. 598 CYNWOOD DRIVE, EASTON, MD 21601 31. Date filed (Max 100) 32_Registrar's Signature State Registrar

| | | | 1 = For State Registrar | State of Ma | ryland | | rtment c | | h | | Reg. No. |)5 | 38389 |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------|-----------------------|-----------------------------------------------------------|----------------------------------------------|-----------------------|--------------------------------------|-----------------------------|--------------|----------------------------------------------------|
| Sh , | Physici /Medio | | 1. Decedent's Name (First, Middle, L Ervin Sylve | | JR | | | | | Month NOVEM | per Lo | 200 | 3. Time of Death |
| | Examir Funeral Director | | 725–14–6814 | rt Hosp | I Tal | t birthday) Yrs. | If Under 1 Y | m, or Location Company Pear If Undays Hour | ler 24 Hrs. | 8. Date of Birt FED 1 | 911 | | place State or Foreign untry) t Virginia |
| | aryland show | <u>.</u> | Usual Residence of Decedent 10a. State 10b. County | | | Town or Lo | | | | | | | 10d. Inside City Limits 1X Yes 2 □ No |
| | with the Ma Sa or 28a-f | Funeral Director | MD. Allega 10e. Street and Number 315 Maryland | | wes | ternp | 10f. Zip Co | ^{de} 1562 | | | 10g. Citizen of | | ıntry? |
| 980 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow or other treumatic event, the Madical Examinar must be mailified at | þ | 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates: | | 11 | Vas Decedent Yes, specify ☐ Yes 2 ☑ | Cuban, Mexi | can, Puerto F | cify Yes or No- Rican, etc.) | | ack, White | nican Indian, o, etc. hite |
| 21215-0036 | d within 72 ho giene. er then "natur . The Medical | Completed | 15. Decedent's (Specify only highest of Elementary/Secondary (0-12) | Education grade completed) College (1-4or 5 | | (Give | ent's Usual O kind of work o OO NOT use r ICK Dr | one during m etired) | nost of workin | og . | 16b. Kind of E | | ndustry |
| Maryland | 2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental the Mental to the Mental trees. | To Be (| 17. Father's Name (First, Middle, La Ervin S. Ha | anna SR | | | | | other's Name Elsie | (First, Middle, Tripl | Maiden Suma ett | me) | |
| Mary | nd 2 should ith and Men 27 is marke reumatic | • | 19a. Informant's Name/Relationship Mary Hanna/ wife | | | | | | | | or, City or Town t, Mary | | ip Code) 21562 |
| Baltimore, | permit. Pages 1 and 2 s Department of Health ar important: If item 27 is eny injury or other treu <u>ance</u> . | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec | Removal from State | cem | etery, crem | ition (Name of atory or other Ga | place) | 11/0 200 | | 20c. Location Keyser, | | Town, State t Virginia |
| Balt | permit. Page Department Important: If eny injury or goce. | | 21. Signature of Funeral Service Lice | sensee Bart | 7 | 1 | Name and A | | 100 | | ral Hon | | d 21562 |
| | Physician / Medical Examiner and physician and physician and the prital-transit | Examiner | 23a. Parf. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b | e. MEN conseque | nce of): | ED CO | ONGÉ | STIVE | HEAL | TFA | | Approximate Interval Between Onset and Death |
| 8760, | cate be execu physicien and the burial-tra | licai | | a. Isc | HE | MIC | C | ARD | 10M | YOPF | THY | | |
| P.O. Box 6 | that the death certifics ed by the attending pt detached for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal d | eath 3 | Ectopic pregr | | | | 1 | ate of deli- | very Day Year |
| | S 60 | þ | Part II. Other significant conditions | s contributing to death bu | it not resulti | ing in the ur | nderlying caus | e given in Pa | art I. | | obacco use con res 2□No | | the cause of death? |
| Division of Vital Records, | The law ate has b page 2 sl | Completed | | | | | | | | 24a. Was autop perfo 1 Yes | rmed? | death? | topsy findings available completion of cause of |
| f Vita | ding Physicien: n. After this certific funeral director, | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 Ø No | Hospital: | nt 2 EF | R/Outpatien | t 3 DOA | Othor | | <i>(Check only o</i> ne 5 ☐ Resid | one) dence 6 □O | ther (Spec | ufy) |
| ision o | ding After fune | Certification: | 27. Manner of Death 1 💆 Natural 5 □ Pending 2 □ Accident investigal 3 □ Suicide 6 □ Could not | t be Diago of Inju | | 8b. Time of Injury | М | Injury at Work? 1 Yes 2 | □No | | now injury occu | | ral Route Number, |
| Div | To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the | Certif | 4 Homicide determine | building, etc | . (Specify) | | | | | City or Tov | vn, State) | | |
| | ne Hoep n 24 hou ne Fune bletely fi | edical | | Physician: To the best of manner: On the basis of and manner sta | examinatio | | | | | | | | |
| | | W | 29b. Signature and title of certifier | on | | | 29c. L | cense numb | ^{er} 478 | | 29d. Date sign | ed (Month | 1. Dey. Year) Er 7, 2005 |
| d | 4VA | | 30. Name and address of person when A a a command | M.D. 625 | Ker | ot A | Print) VENU | e (| lumb | serlar | d, M | Dó | er 7, 2005 81502 |
| | Sta Regist | ate rar | 31. Date field (Month, Day, Year) NOV - 8 | 2005 32. Registra | r's Signatu | re K | Goods 1 | | | | | | |

| | | | For State Registrar | State of M | laryland | | rtment of H | | Mental Hy | giene | 5 3 | 38390 |
|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------|----------------------------------------|------------------------------------------------------------------|----------------------------------------|---------------------------------------|-----------------------------------------|---------------------------|----------------------------------------------|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, I | Last) | | - , | | | 2. Date of De Month | aath | Year | 3. Time of Death G. 4/ A M |
| 9 | Examir | | | eral Hos | pita | ast birthday) | 4b. City, Town, or Berli | Location of Deat | | 4c. County o | cesi | |
| w ex | Funeral Director | | 025-16-8748 Usual Residence of Decedent | 1□M 2 XF | 81 | Yrs. | Months Days | Hours Min. | (Month, De 09-21- | y, Year) | | ace (State or Foreign try) achusetts |
| | Maryland f ehow | ō | 10a. State 10b. County | | | , Town or Lo | cation | | | | 10 | Od. Inside City Limits |
| | or 28e- | Direct | MD Worces 10e. Street and Number | | Berl | Lin | 10f. Zip Code | | | 10g. Citizen of Wh | nat Count | |
| | ter death v Itema 23a | nerai | 9715 Healthway D | rive 12. Was Deceden Armed Forces | | | 21811 | spanic Origin? (S | pecify Yes or No | | | |
| 036 | ours after death with the Maryian ref', or Itema 23a or 28e-f ehow Exeminer must be notified at | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | | No | | Yes, specify Cuba | Specify: | o Fican, etc.) | Specify: | , White, e | |
| 21215-0036 | n 72 h '*natu | Completed by Funeral Director | 15. Decedent's (Specify only highest of Elementary/Secondary (0-12) | grade completed) College (1-4or | 5+) | (Give . life. L | ent's Usual Occupa kind of work done of OO NOT use retired | furina most of wor | rking | 16b. Kind of Bus | | ustry |
| 1d 21 | e filed wall Hygien other the | Be Col | 8 17. Father's Name (First, Middle, La | none st) | | Home | emaker | 18. Mother's Nar | ne (First, Middle | Own HC | | |
| Maryland | s 1 and 2 should be filed within f Health and Mental Hygiene. Itam 27 le marked other than other traumatic event, tre M | Tof | Victor St. Dawn 19a. Informant's Name/Relationship | (Type, Print) | | 19b. Mailin | n Address (Street a | Unkno | | er, City or Town, S | itate Zin | Codel |
| | es 1 and 2 and 2 of Health ar | | Shirley Walston | | 20h Bi | 607 (| Clyde Ave | | itland, | MD 21826 | 5 | |
| Baltimore, | permit. Pages: Dependent of h Importent: If its any injury or ot | | 20a. Method of Disposition Burial 2 Cremation 3 4 Donation 5 Other (Spe | | C6 | metery, crem | sition <i>(Name of</i> latory or other place l Cemeter | | 7/2005 | 20c. Location - C | | |
| Balt | Deports Import any in | < | 21 Signature of Funeral S vice V | 1426 | M00295 | | Name and Addres | | | | 100 | 01050 |
| | Physician | | 23a Part1. Enter the disease, or co shock, or heart failure. List on Inmediate Cause (Final disease or condition | mplications had cause by one cause on each | d the death line. | . Do not ente | ir the mode of dying | g, such as cardiac | or respiratory a | cess Anne rrest, | İ | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or a | s a consequ | | act in | fectri | 7 | | 2 | weeks |
| | uted | Examiner | Esquertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | s a consequ | e ce of): | <i>COT 1.1</i> | | | | | |
| 68760, | icate be executed physician and s the burial-transit | dicai Exa | resulting in death) Last | Due to (or as | s a consequ | ence of): | | | | | | |
| _ | | (0) | IF FEMALE: | 23c If was outcome | o of program | 201 | | | | 1 | - | |
| /21/1924 13/2005 ds, P.O. Box | ne death the atte | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal | death 3□ | Ectopic pregnancy Other (specify) | | | 23d. Date Montt | | y Day Year |
| 00.6 9/21/19 00.0 11/13/2003 Records, P.C | w requires that the d been signed by the shuld be detached | þ | Part II. Other significant conditions | | but not resu | lting in the un | derlying cause give | n in Part I. | | obacco use contrib Yes 2 No 3 | | bly 4 Unknown |
| | The law rate has be bage 2 sh | Completed | demention | Mation | | | | | | osy prii rmed? / de | ere autoporto com ath? | sy findings available pletion of cause of |
| / ク <i>48</i> Vital | sician: certifica rector, p | Be | 25. Was case referred to medical examiner? | Hospital: | | - | 3 DOA Othe | | 1 | one) | | |
| // 2// 3// ion of | To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | ation: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investigat | 28a. Date of Inj (Month, Da | | R/Outpatient 28b. Time of Injury | 28c. Injury Work | 4 Li Nursing n | | dence 6 Other | | |
| Rith O255 Divisi | al or Atter after de: 7 Directo d in by th | Certification: | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | 28e. Place of In building, e | jury - At hor tc. (Specify) | ne, farm, stre | et, factory, office | | 28f. Location (S City or Tox | Street and Number vn, State) | or Rural | Route Number, |
| | Mospita 24 hours Funera etely filler | Medical C | 29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex | Physician: To the besi aminer: On the basis and manner s | of examinati | vledge, death on and/or inv | occurred at the time estigation, in my op | e, date and place inion, death occu | , and due to the rred at the time, | cause(s) and mann date and place, an | ner as sta | ited. the cause(s) |
| | To th within To th comp | Me | 29b. Signature and title of certifier | Mille | | un | 29c. License | (.) | | 29d. Date signed (| | |
| | | | 30. Name and address of person wh | n completed chrise of | death (Item | 23a) (Type F | Print) | 00679 | | 11-13- | | |
| | Sta | te | KRISTINE CRIF 31. Date filed (Month, Day, Year) | 32. Regist | rar's Signate | lle ear | | SHUAY, | FENU | ICK ISLA | NO | DE 1994 |
| | Registr | ar | NOV 1 (| 2005 | Suc | K 1 | back | | | | | |

State of Maryland / Department of Health and Mental Hygiene 38391 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year LUCILLE HOPKINS В. NOVEMBER 12:35 A^M 4, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 092-40-4835 56 Yrs. Director NOV 6, 1948 NEW YORK Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any njury or other traumatic event, the Medical Examirat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MARYLAND ANNE ARUNDEL GAMBRILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2222 DAIRY FARM ROAD 21054 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏹 No Specify: δ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PAINT COMPANY 12 BOOKKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VINCENT SGANGA ပ္ JOHANNA SATRIANO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD J. HOPKINS/HUSBAND 2222 DAIRY FARM ROAD, GAMBRILLS, MARYLAND 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/08/2005 HUNTT CREMATORY WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME PKun 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer, Non-Small cell **Physician** una /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-trae resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to acco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Tes 2 No Certification: To 2 ER/Outpatient 3 DOA this To the Funeral Director: After th completely filled in by the funeral 28b. Time of Injury 27. Manner of Death Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number DS 2830 weins MD 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) K Road #300 Wernermy 400 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

| | | | For State Registrar | | yland / Dep | artment of Health | and Mental Hyg | _ | 38392 |
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| | Physicia | an | 1. Decedent's Name (First, Middle, | | 1. | | 2. Date of Dea | | 3. Time of Death |
| | /Medic | | John | Joseph | Haski | | Novembe | | |
| 7 | Examin | er | 4a. Facility Name (If not institution, Beverly Healt | | • | 4b. City, Town, or Location Frederi | | 4c. County of De | eath rederick |
| l. | | | | | n yrs. last birthday, | | 24 Hrs. 0 m | | irthplace (State or Foreign |
| | Funeral Director | | 119-20-9236 Usual Residence of Decedent | 15 M 2□F 7 | | Months Days Hours | Min. (Month, Day Aug. 20 | , 1928 9. E | New York |
| | yland | | 10a. State 10b. County | | oc. City, Town or L | | | | 10d. Inside City Limits |
| | a-fsl | ctor | Maryland Fr | ederick | | Frederic | ζ | | 1 ☑ Yes 2 □ No |
| | permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be routified at once. | Completed by Funeral Director | 10e. Street and Number 5955 Quinn Orch | ard Road | | 10f. Zip Code 21704 | | 10g. Citizen of What (| |
| | ems ems | ner | 11. Marital Status | 12. Was Decedent Eve Armed Forces? | or in U.S. 13. | Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica | rigin? (Specify Yes or No- n, Puerto Rican, etc.) | 14. Race - Ar Black, Wi | nerican Indian, |
| 36 | or it | y Fu | 1 Never Married 2 Marrie | 1 ☐ Yes 2 X No If Yes, Give | | 1 ☐ Yes 2 ☒ No Specify | | Specify: | White |
| 21215-0036 | ural', | q p | 3 Widowed 4 Divorced | Year or Dates: | | | | | |
| 15 | n 72 "nat | lete | 15. Decedent's (Specify only highest | grade completed) | (Give | dent's Usual Occupation kind of work done during mo. DO NOT use retired) | st of working | 16b. Kind of Busines | ss/Industry |
| 12 | withi iene. than | mo | Elementary/Secondary (0-12) | College (1-4or 5+) | _ | ance Agent | | Theurance | Industry |
| | filed Hyg other | Be C | 17. Father's Name (First, Middle, L | ast) | 11100 | | er's Name (First, Middle, | | . IIIQGSCIY |
| lan. | uld be Aenta rked tic ev | To B | Clair B. Haski | ns | | Eli | zabeth Cost | e11o | |
| Maryland | should have | | 19a. Informant's Name/Relationsh | | | ng Address (Street and Numb | er or Rural Route Numbe | r, City or Town, State | . Zip Code) |
| | and 2 salth n 27 i | 1 | Claire M. Grabo | | | Byron Circle, | | | |
| ore | of He | | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation | | 20b. Place of Disponentery, cre | osition (Name of matory or other place) Crematory No | Date 21 2005 | 20c. Location - City | or Town, State |
| Ë | Pag Iment tent: jury c | | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. | ochy) | | | | | irg, Maryland |
| Baltimore | permit Depari impori any in | | 21. Signal re of Funeral Service L 23a. Part1. Enter the disease, or o shock, or heart failure. List o | . //2 | M00021 ² | 2. Name and Address of Facil Keeney and Ba 106 Fast Chur | sford Funera | al Home Frederick | MD 21701 |
| | | | 23a. Part1. Enter the disease, or of shock, or heart failure. List of | complications that caused the only one cause on each line. | e death. Do not en | ter the mode of dying, such as | cardiac or respiratory arr | est, | Approximate Interval Between Onset and Death |
| | Physician / /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Candi | ac av | | | | Silbertaile Beatin |
| | Examiner | | | Due to (or as a c | onsequence of): | 10. | | | |
| | | er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a co | onsequence of): | rry juury. | | | |
| V | outed od ansit | Examiner | Cause (Disease or injury that initiated events | C | | • | | | |
| oʻ | e exerian ar | EX | resulting in death) Last | Due to (or as a co | onsequence of): | | | | |
| 68760, | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | dicai | | d | | | | | |
| 9 × | entific ding p | Physician/Med | IF FEMALE: | 23c. If yes, outcome of p | | | | | |
| Box | attendation for us | ian | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 2 4 Pregnant at tim | Fetal death 3 | Ectopic pregnancy Other (specify) | - | 23d. Date of d Month | elivery Da y Year |
| P.O. | that the death ned by the atter detached for u | ysic | 1 □ Yes 2 □ No 9 □ Unknown | 9 Unknown | o or doutil 5 | | | | |
| | res that igned by be deta | by Pr | Part II. Other significant condition | ns contributing to death but n | ot resulting in the u | nderlying cause given in Part | I. 23e. Did to | bacco use contribute | to the cause of death? |
| Records, | w require: been sig should bo | ed b | | | | | 1 🗆 Y | es 2 No 3 I | Probably 4 Unknown |
| ပ္ပ | aw requisite been 2 should | Completed | | | | | 24a. Was a | in 24b. Were | autopsy findings available |
| Ä | The lav | E O | | | | | perfor | med? death? | |
| Vital | | Be C | 25. Was case referred to medical examiner? | | | 26. Plac | e of Death (Check only or | | |
| of V | Physicien: this certificatal director, I | 일 | 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient | 2 ER/Outpatie | | ursing Home 5 🗆 Resid | ence 6 Other (Sp | pecify) |
| ם | | | 27. Manner of Death 1 ■ Natural 5 ■ Pending | 28a. Date of Injury (Month, Day Ye | 28b. Time o Injury | Work? | | ow injury occurred | |
| sio | Attending r death. sctor: After by the fune | cati | 2 Accident investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation inves | ation | | M 1 Yes 2 | | | |
| Division | i or Al after d Direct I in by | Certification; | 4 Homicide determin | | - At nome, tarm, st Specify) | reet, factory, office | City or Town | treet and Number or i n, State) | Hurai Houte Number, |
| | To the Hospitei or Attend within 24 hours after death To the Funerel Director: completely filled in by the | Medical C | 29a. Certifier 1 Certifying (Check only one) 2 Medical E | p Physicien: To the best of m xaminer: On the basis of ex and manner stated | amination and/or in | h occurred at the time, date an vestigation, in my opinion, dea | nd place, and due to the cath occurred at the time, d | ause(s) and manner ate and place, and d | as stated. ue to the cause(s) |
| | o the | Mec | 29b. Signature and title of certifier | and manner stated | | 29c. License number | 2 | 9d. Date signed (Mo. | nth, Day, Year) |
| • | F ≤ F ŏ | | 1 de | | | 1 ook | 0417 | 11/2/10 | T |
| | - 10 | | 17 - | | | 12000 | , / | , - , 0 | • |
| | .0 | - 5 | 30. Name and address of person w | tho completed cause of deat | h (Item 23a) (Type. | Print) | | | |
| | 10 | | 30. Name and address of person w Hemen Shah | 2005 against aris | Thoma | Print) S Johnson | Dr. Fre | device | MD 21702 |

| | | | 1- For State of Maryland / Department of Health and Certificate of Death | d Mental H | ygiene Reg. Ná | 2000 | 38303 |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|------------------------|--------------------------|--------------------------------------------------|
| | Discoulation in the | | 1. Decedent's Name (First, Middle, Last) | 2. Date of I | | | 3. Time of Death |
| | Physici /Medic | | WILLIAM EDWARD JENKINS, JR. | Novem | ber | 7, 200 | . 2 1/1/2 /2 11 |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De | eath | 4c. | County of Dea | |
| _ | F | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H | Hrs. R Date of F | Righ | Allegi | othplace (State or Foreign |
| Н | Funeral Director | | | Ain. (Month, L | Day, Year) | | RYLAND |
| | D . | | Usual Residence of Decedent | | | - ITA | |
| | lanyia shov | ž | 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits 1 Yes 2 □ No |
| | the N | ect | MD ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code | | 10c Cit | tizen of What C | |
| | 3a or | Funeral Director | 509 ROSE HILL AVENUE 21502 | | | .S.A. | ountry ? |
| | death ms 2 | nera | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? | (Specify Yes or N | | 14. Race - Am | |
| 9 | after or Ite | /Fu | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify: | uerto Hican, etc.) | | Black, Wh | |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examiner must be motified at | d by | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | | | | WHITE |
| 5 | in 72 "nat | Completed | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wife. DO NDT use retired) | working | | ind of Business | • |
| 212 | yiene. | шо | Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATOR | | | CORPORA' | _ |
| pu | be filed tal Hygi d other event, II | BeC | 17. Father's Name (First, Middle, Last) 18. Mother's N | Name (First, Midd | le, Maiden | Sumame) | |
| yla | 2 should be filed and Mental Hygi is marked other aumatic event, I | To 1 | | E LILLIA | | | |
| Maryland | 12 sh h and 7 is m traum | | 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or</i> | | | | |
| | ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, Ite Medical Examiner must be notified at | | SHIRLEY JENKINS / WIFE 509 ROSE HILL AVENUTE 20a. Method of Disposition (Name of | Date Date | | ocation - City o | 21502 |
| Baltimore, | permit, Pages 1 an Department of Heal Important: If item 2 any injury or other ance. | | 1 \(\text{ZBurial}\) 2 \(\text{Cremation}\) 3 \(\text{Removal from State}\) 4 \(\text{Donation}\) 5 \(\text{Other}\) (Specify), HTT.I.CRFST MFMT. \(\text{PARK}\) 1.1 \(\frac{1}{2}\) | 11 /2005 | | | |
| altii | mit. F partm sortar / injur | | 21. Signature of Funeral Service Licensia # 22. Name and Address of Facility | | | JMBERLA | ND, MD |
| m | permi Depa Impo any ir | | UPCHURCH FUNERAL 202 GREENE STREET | L HOME, | P.A. ERLAN | JD. MD | 21502 |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. | diac or respiratory | arrest, | 127 112 | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Final disease or condition a. LUNG CANCER | | | | Onset and Death YEARS |
| | /Medical Examiner | | Due to (or as a consequence of): | | | | a Danie |
| | | er | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irijury that initiated events | | | | |
| oʻ | an an irial-tr | | resulting in death) Last Due to (or as a consequence of): | | | | |
| 8760, | death certificate be executed e attending physician and od for use as the burial-transit | dicai | d | | | | |
| 9 xo | entific ding p | /Мес | IF FEMALE: 23c. If yes, outcome of pregnancy | | | | |
| $\mathbf{\Omega}$ | leath certifi attending I for use as | cian | in the past 12 months? | | 2 | 23d. Date of de Month | livery Day Year |
| o. | that the de ed by the detached | Physician/Me | 1 Yes 2 No 9 Unknown 9 Unknown | | | | |
| ۳, | The law requires that the site has been signed by the page 2 should be detached. | by PI | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did | tobacco u | ise contribute t | o the cause of death? |
| ord | w require been sig should b | ted | CORONARY ARTERY DISEASE | 102 | X Yes 2[| □No 3□P | robably 4 Dunknown |
| Records, | e law r has be ge 2 sh | Completed | | 24a. Wa | s an opsy | 24b. Were a | utopsy findings available completion of cause of |
| ₩ ₩ | cate h | Con | | | formed? | death? | s 2 No |
| Vital | Physician: Th r this certificate ral director, pag | Be | examiner: A4. Hospital: A4. | Death (Check only | | | |
| ot | Phys r this ral dii | . To | 1 Sunpatient 2 EH/Outpatient 3 DOA 4 Nursing | g Home 5 Res | | | ecify) |
| ion | Attending Property death. | atlor | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 2 | | West injury | , 00001100 | |
| Division of | I or Attendation after deati | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | (Street and | | ural Route Number, |
| Ö | itel or A rs after ral Directed in by | Cer | | | | , | |
| | To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | Medical | 29a. Certifier (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open) (Check only open | ace, and due to the ccurred at the time | cause(s) , date and | and manner a | s stated. e to the cause(s) |
| | o the o the comple | Med | one) and manner stated. 29b. Signature and title of certifier 29c. License number | | | e signed (Mont | |
| • | 10 | | De ren M.D D54411 | | | | 7,2005 |
| | 10 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | uve | ,, 4,20, | 1,2003 |
| | MN | | BEVERLY CALKINS M.D. 500 Memorial Avenue Cumberlar | nd, Mary | Land | 21502 | |
| | Sta Registr | | 31. Date filed (Month Day, Year) 32. Registrar's Signature | | | | |

| | | | 1 - For State Registrar | State of Ma | aryland / Depa | artment of I | | | giene | 5 38394 | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------|------------------------------------------|-----------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------|---|
| | Physici | | 1. Decedent's Name <i>(First, Middle, La</i> s Anna Grace Jenki | • | | | | 2. Date of De Month | | 3. Time of Death 6:20 A M | |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | | mo | | or Location of Dea | th | 4c. County | | |
| | Funeral | | Frostburg Village N 5. Social Security Number 6. Se | | e (In yrs. last birthday) | Cumber If Under 1 Year Months Days | | | Allega | 9. Birthplace (State or Foreign | 7 |
| | Director | | Usual Residence of Decedent | Z W 2X | 83 Yrs. | | | Mar 21 | i, 1922 | MD Country) | _ |
| | Manylan f show | or | MD 10b. County Allegan | у | 10c. City, Town or Lo | aptown | | | | 10d. Inside City Limits 1 □ Yes 2 □ No | |
| | or 28a- | Funeral Director | 10e. Street and Number | | <u> </u> | 10f. Zip Code | | | 10g. Citizen of V | | _ |
| | eath w | eral | 14919 Grant Stree | 12. Was Decedent | Ever in U.S. 13 | | 21502 | Specify Ves or No | US | e - American Indian, | _ |
| 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-1 show appropriation of the properties of the propriate of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the pr | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 If Yes, Give X Year or Dates: | No | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No | Specify: | rto Rican, etc.) | Blac | k, White, etc. | |
| 21215-0036 | n 72 ho "natur | leted | 15. Decedent's Ed (Specify only highest grad | | 16a. Dece (Give | dent's Usual Occup kind of work done DO NOT use retire | pation during most of wo | orking | 16b. Kind of Bu | | _ |
| | filed withi Hygiene. other then | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | Homer | | | | Own Hor | me | _ |
| land | should be filed withir nd Mental Hygiene. marked other then imetic event, ILEM | To Be | 17. Father's Name (First, Middle, Last) Leonard J. Lease |) | | | | me (First, Middle, Ibright) Le | | e) | |
| Maryland | 2 should n and Men is marke reumetic | - | 19a. Informant's Name/Relationship (T) Norman Jenkins | уре, Print) SON | | ng Address (Street 06 Brant F | and Number or R | ural Route Numbe | er, City or Town, | State, Zip Code) MD 21502 | _ |
| | of Health of Health litem 27 | | 20a. Method of Disposition | | 20b. Place of Dispo | | Ī | Date | 20c. Location - | City or Town, State | _ |
| Baltimore, | permit. Pages Department of i Importent: if it any injury or o | | 1 XBurial 2 ☐ Cremation 3 ☐ I 1 4 ☐ Donation 5 ☐ Other (Specify, | | Sunset Men | norial Park | | | Cumbe | rland MD | |
| Ba | permil Depar Impor any in | | 21. Signature Fureral Service Licens | *4M | M 22 | Name and Address Scarpell | ss of Facility I Funeral H | lome, P.A. | land MD C | 14500 | |
| | | | 23a. Part 1. Enter the disease, or comp shock or heart failure. List only o | lications to at caused ne cause on each lin | the death. Do not ent | er the mode of dyir | ig, such as cardia | e; Cumber c or respiratory ar | rrest, | Approximate Interval Between | _ |
| | Physician /Medical | | Immedia e Cause (Final disease or condition resulting in death) | · | ASTATIC / | BREAST (| ZARCIN | 10MA | | Onset and Death | _ |
| | Examiner | _ | Sequentially list conditions, | b | | | | | | | |
| J | outed id ansit | Examlner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | a consequence of): | | | | | | |
| 8760, | cate be executed physician and the burial-transit | al Exc | resulting in death) Last | Due to (or as | a consequence of); | | | | | | |
| 9 | tificate ng phys as the | ledical | | d | | | | | | | _ |
| Вох | that the death certiff ed by the attending detached for use as | Physician/Me | in the past 12 months? | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date Mon | of delivery oth Day Year | |
| <u>Ф</u> О | at the d by the stached | hysic | 1 ☐ Yes 2 ☐No 9 ☐ Unknown | 9□ Unknown | | | | | | | |
| | The law requires that the death certifi site has been signed by the attending bage 2 should be detached for use as | by | Part II. Other significant conditions co | ntributing to death be | ut not resulting in the u | nderlying cause giv | en in Part I. | | | ibute to the cause of death? 3 Probably 4 Unknown | |
| I Records, | | Completed | | | | | · | | rmed? pi | Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No | |
| Vital | ysician: Th is certificate director, pag | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No | Hospital: | at 2 EB/Outration | oth Oth | | ath (Check only o | | | _ |
| Division of | ding Ph h. After th funeral | | 27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation | 28a. Date of Injur (Month, Day | y 28b. Time of | 28c. Injun Work | / at | dome 5 ☐ Resid | now injury occurre | | i |
| Divis | - 0 | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injubul | ury - At home, farm, str c. (Specify) | eet, factory, office | | 28f. Location (S City or Tow | | r or Rural Route Number, | 1 |
| | To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the | edical | 29a. Certifier 1 Certifying Phy (Check only one) | sician: To the best of ner: On the basis of and manner sta | of my knowledge, death examination and/or invited. | n occurred at the tin restigation, in my o | ne, date and place pinion, death occu | e, and due to the ourred at the time, o | cause(s) and man date and place, a | nner as stated. nd due to the cause(s) | _ |
| | To the comp | Σ | 29b. Signature and title of certifier | elhn | | 29c. Licenso | | | _ | (Month, Dey, Year) | |
| | | | 30. Name and address of person who co | ompleted cause of de | eath (Item 23a) (Type. | D26 | | | | ER 21, 2005 | |
| | lo | | 31. Harjit Sidhy v.M.D. | od n | r's Signature 925 B | ishop Wa | lsh Road | Cumberl | and MD | 21502 | |
| | Sta Registra | _ | NOV 2 9 2005 | Hegistra | S Signature Source | de la | | | | | |

| | | | 1 - For State Registrar | State of | f Marylar | | artment of F rtificate of | | Mental Hy | giene | 005 | 38395 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------|----------------------------------|--------------------------------------------|-----------------------------------------|------------------------------------------|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| 2 | Physical | ٠, | 1. Decedent's Name (First, Midd | lle, Last) | | | | | 2. Date of De | | Year | 3. Time of Death |
| | Physici /Medio | | Eleanor T. Ke | ershner | | | | | Month 11 | 9 | 2005 | 7:45 A M |
| 1 | Examir | er | 4a. Facility Name (If not institution Atlantic Gener | - | | | 4b. City, Town, o | | ath | 4c. C | County of Death | |
| (9) | | | 5. Social Security Number | | 7. Age (In yrs. | last hirthday) | Berlir If Under 1 Year | If Under 24 H | S. 8 Date of Bir | rth | Worces | |
| | Funeral Director | | 216-12-9103 | 1□M 2X0F | 83 | Yrs. | Months Days | Hours Mi | | 2 Year) | Col | place (State or Foreign intry) PA |
| | p , | | Usual Residence of Decedent 10a, State 10b, Count | | 140.00 | | | | | | | |
| | ehov | 'n | | ester | | ty,Town or Lo Berlin | cation | | | | | 10d. Inside City Limits 1 ☐ Yes 2 XNo |
| | the N 28e-f | ect | 10e, Street and Number | | | | 10f. Zip Code | | | 10a Citiza | en of What Cou | |
| | 3a or | | 8 Frigate Run | | | | 1 | 811 | | _ | JSA | arti y : |
| | death | Funeral Director | 11. Marital Status | 12. Was Dece Armed For | dent Ever in U | .S. 13. | Was Decedent of H | | Specify Yes or No | | . Race - Amer | ican Indian, |
| 5-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Iteme 23a or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be notilled at once. | by | 1 ☐ Never Married 2 ☐ Mai 3 🖄 Widowed 4 ☐ Divorced | rned 1 ☐ Yes | 2 🕅 No | | l ⊟ Yes 2⊠ No | Specify: | arto Alcari, etc.) | | Black, White Specify: Wh | ite |
| 20 | 72 ho natur | eted | 15. Deceder | nt's Education st grade completed) | | 16a. Dece | ient's Usual Occup | pation | orkina | 16b. Kind | d of Business/li | ndustry |
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| d 21 | filed v Hygie ther t | | 17. Father's Name (First, Middle, | Last) | | Nur | se | 18 Mother's N | ame (First, Middle | | alth Ca | re |
| ryland | ld be ental ked o | То Ве | Louis Morgan | | | | | | oeth Seil | | umame) | |
| 2 | shou ind M mar umat | F | 19a. Informant's Name/Relation | ` | | 19b. Mailir | g Address (Street | | | | Town, State, Zi | p Code) |
| 2 | and 2 salth a n 27 is | | Thomas Kershn | er | | 8 Fr | igate Ru | n, Berli | n, MD 21 | 811 | | |
| Baltimore | of He | | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation | 3 □Removal from S | | Place of Dispo cemetery, cren | sition (Name of natory or other place | сө) | Date | 20c. Loca | ation - City or T | own, State |
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| 8 | | | 23a. Part1. Enter the disease, o shock, or heart failure. Lis | r complications that ca t only one cause on ea | used the deat | h. Do not ent | er the mode of dyir | ng, such as cardi | ac or respiratory a | rrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | _ a | 52 | P50 | 2 | | | | | Deset and Death |
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|). Box | The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as | Physiclan/M | 23b. Was decedent pregnant in the past 12 pronts? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown | | rth 2 ☐ Feta unt at time of d | death 3 | Ectopic pregnancy Other (specify) | <u>'</u> | | 23 | d. Date of deliv Month | ery Day Year |
| P.0 | that the de ned by the a detached f | | Part II. Other significant conditi | Ons contributing to de | ath but not res | ulting in the ur | nderlying cause giv | en in Part I | 23e Did t | obacco use | contribute to t | he cause of death? |
| of Vital Records, | w requires that been signed should be det | ted by | | | | | | | | Yes 2 | | . / |
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| a | | | 05.14 | | | | | | 1 ☐ Yes | rmed? 2 No | death? 1 ☐ Yes | 2 🗆 No |
| Ζ | Physicien: this certificinal director. | To Be | 25. Was case referred to medica examiner? 1 Yes 2 No | Hospital: | wient 2 | ER/Outpatien | 1 3□ DOA Oth | 00 | eath Check only o | 7 | 701 (2 | , , |
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| | To the within To the complete | Me | 29b. Signature and title of contrib | ЭГ | | | 29c. Licens | e number | | 29d. Date : | signed (Month, | Day, Year) |
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| ٤ | 37 6 | | 30. Name and address of person Au Rose A | who completed cause | of death (Item | 23a) (Type, I | 1209 C | lews kel | the Fa | euse & | Tslew | 1, Dc 19944 |
| | Sta Registr | | 31. Date filed (Month, Day, Year, NOV 1 4 | 2005 | gistrar's Signa | ture Apr | where | - 62 D.T. | 1 | | | , |

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| 30. Name and address of person who combleted cause of death (Itém 23a) (Type, Print) 2 Ahir yousaf M.D. 2417 Solo mons Island Rd. Hunting town Md. 20639 State Registrar NOV 0 4 2005 Hunting to Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Ma | | | | 7 | VVV | | | /101 | | | ~3 |
| State Registrar NOV 0 4 2005 Malure the Charles | | 15 | | 30. Name and address of person | who completed cause | of death (Item 23a) (Type | Print) | T | 0 1 // | L ' I | L . / Mal |
| Registrar NOV 0 4 2005 Males & Locales | | 11 | | AHTIR U | DUSAT IV | distract Signature | 1 DOLD MON | 15 ISland | Kd. H | UNTINGT | OWN INd. 20639 |
| | | | | NO | / 0 4 2005► | Glature K | Spart s | | | - | |

| | | | 1 - For State Registrar | State of Ma | aryland / L | лера Сел | artment of F rtificate of | ieaith and Death | mental Hy | giery) Reg. No | | 38397 |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------|--------------------|---------------------------------------------------------|----------------------------------------|-----------------------------------|-------------------------|--------------------------------------------|-------------------------------------|
| | # Dhysisi | | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of D Month | | | 3. Time of Death |
| | Physici /Medic | | Jessie Halstea | d Kirk | | | | | Novem | | 9, 200 | 3 • 20n M |
| 1 | Examin | er | 4a. Facility Name (If not institution, give | re street and number) | | | 4b. City, Town, o | Location of Dea | th | 40 | . County of De | eath |
| | | | Holy Cross Hos | | | | | Spring | | | Montgo | mery |
| В | Funeral | | , and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second | Sex 7. Ag I□M 2x□F | e (In yrs. last bir | thday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | (Month D | rth av Year | 9. 8 | Sirthplace (State or Foreign |
| لمر | Director | | 061-14-9397 Usual Residence of Decedent | | 86 | | | | Dec. 2 | 8, 1 | 918 Ne | w Jersey |
| | yland | | 10a. State 10b. County | | 10c. City, Tow | n or Lo | cation | | | | | 10d. Inside City Limits |
| | B-f s | ior | Maryland Montgo | omery | Kensir | igto | on | | | | | 1 X Yes 2 ☐ No |
| | or 28 | Sire | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Ci | tizen of What | Country? |
| | 23a | rai | 3620 Littledale 1 | Road, #216 | | | 20895 | | | | USA | |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner is used by roulified at once. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 if Yes, Give Year or Dates: | | | Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 🏋 ☐ No | | Specify Yes or Norto Rican, etc.) | 0- | 14. Race - Ar. Black, Wi Specify: Wh | |
| ŏ | 2 hou | ted | 15. Decedent's E | ducation | 16a. | Deced | dent's Usual Occup | ation | | 16b. K | (ind of Busines | :s/Industry |
| 2 | thin 7 | jp le | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5 | i+) | life. I | kind of work done of DO NOT use retired | during most of wo () | orking | | | , |
| 2 | ed wil | Completed | | 5+ | | Но | memaker | | | | Own | Home |
| <u>n</u> | tal Hydrad oth | Be | 17. Father's Name (First, Middle, Last | | | | | | me (First, Middle | | | |
| 3 | Men Marke Marke | T ₀ | William Henry Ha | | | | | | Wallace | | | |
| Maryland | 12 sh h and 7 le n treun | | 19a. Informant's Name/Relationship (| | | | g Address (Street | | | | | |
| 6 | Heall Heall em 2 | | William H. Kirk/ 20a. Method of Disposition | Son | 20b. Place of | 514 | Bolton Sition (Name of | Street, | Baltimor Date | ce, 1 | Marylan | d 21217 |
| 2 | ages t: # # | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | cemeter | ry, cren | natory or other place n Crematory | 1100 | ember 11 | | , | |
| Baltimore, | orten | | 21. Signature of Foreral Service Licer | | red opo. | | | | 005 | Alex | andria | , Virginia |
| m | Ded ding | | (undow) | 2 Cole | | 50 | Name and Address ancis J. O Univer: | collins sity Blv | funeral d, W, Si | l Hon Llver | ne Inc. Sprin | g, MD 20901 |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused | the death. Do r | | | | | | F | Approximate |
| | Physician | | Immediate Cause (Final disease or condition | a Congesti | | + E | n:1 | | | | | Interval Between Onset and Death |
| G.S. | /Medical | | resulting in death) | | a consequence of | | arrure | | | | | 2 Months |
| | Examiner | | Sequentially list conditions. | Atrial F | | | n | | | | | l Year |
| | Sit 9d | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequence o | of): | | | | | | |
| _ | icate be executed physician and s the burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to (or as | a consequence o | of): | | | | | | |
| 9 | be e sician buria | | | 300 10 (0, 00 | 2 00/130400/100 | ۵۱). | | | | | | |
| 68/60, | tificate be executed g physician and as the burial-transit | edical | | d | | | | | | | | |
| ROX | | | IF FEMALE: 23b. Was decedent pregnant | 23c. ff yes, outcome | | _ | | | | | 23d. Date of de | alivery |
| | requires that the death cer een signed by the attendir hould be detached for use | Physician/N | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 ∐Live birth 4 □ Pregnant at 9 □ Unknown | | | Ectopic pregnancy Other (specify) | | | | Month | Day Year |
| 7 | | by Pr | Part If. Other significant conditions of | ontributing to death bu | it not resulting in | the un | derlying cause give | n in Part I. | 23e. Did t | obacco u | se contribute | to the cause of death? |
| Hecords, | w requires been signe should be | pa D | Alzheimer's Deme | ntia | | | | | 10 | Yes 2 | INo 3□F | robabfy 4 Unknown |
| ပ္တ | | Completed | | | | | | | 24a. Was | an | 24b. Were a | utopsy findings available |
| ř | The I | E | | | | | | | | rmed? | prior to death? | completion of cause of |
| VITal | ysician: The law is certificate has b director, page 2 s | Bec | 25. Was case referred to medical examiner? | | | | | 26. Place of Dea | 1 ☐ Yes ath (Check only o | 2 % No | 1 10 10 | s 2 No |
| 010 | > 0 0 | ٥ | 1 ☐ Yes 21€ No | Hospital: 1 🕱 Inpatier | nt 2 ER/Out | tpatient | 3□ DOA Othe | r: 4 Nursing H | lome 5 ☐ Resid | dence (| 6 □Other (Sp | ecify) |
| | ing P | Ö | 27. Manner of Death 1 ☐Natural 5 ☐ Pending | 28a. Date of Injur (Month, Day | y Year) 28b. T | ime of | 28c. injury Work | at ? | 28d. Describe I | how infur | y occurred | |
| Slon | Attending ir death. sctor: After by the fune | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | | | es 2 □No | | | | |
| <u>≥</u> | s effer of All Direct all Direct ad in by | Certification: | 4 Homicide determined | 28e. Pface of fnju building, etc | ry - At home, far . <i>(Specify)</i> | rm, stre | et, factory, office | | 28f. Location (S City or Tox | Street and vn. State | d Number or P) | lural Route Number, |
| | To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral | edicai | 29a. Certifier (Check only one) Check only one) | ysician: To the best on niner: On the basis of and manner sta | examination and | , death dor inv | occurred at the time estigation, in my op | e, date and place inion, death occu | and due to the | cause(s) date and | and manner a place, and du | s stated. e to the cause(s) |
| | To th Within To th comp | Me | 29b. Signature and de of certifier | 0 - | ` | | 29c. License | | _ | 29d. Dat | e signed (Mon | th, Day, Year) |
| | | | Marina | * DANK | | | P 3 | 19/5 | | Nov | vember | 10, 2005 |
| | 1> | | 30. Name and address of person who | | | , | • | | | | | |
| | | | Jeffrey Indrisa | | | ckwo | ood Drive | , #280, | Silver | Spri | ng, MD | 20901 |
| | Stat | e | 31. Date filed (Month, Day, Year) | 32 Tegistra | r's Signature | Mary | ack o | | | | | |

| | | | 1 - For State Registrar | State of Maryland / Dep Ce | partment of Health and ertificate of Death | d Mental Hygie Reg. | |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------|
| | Dhuciai | | Decedent's Name (First, Middle, La | ist) | | 2. Date of Death Month | Day Year 3. Time of Death |
| | Physici /Medic | | Marion Isabelle | Kelley | | November | 4, 2005 11:11p M |
| 1 | Examir | | 4a. Facility Name (If not institution, given | ve street and number) | 4b. City, Town, or Location of De | eath | 4c. County of Death |
| | | | Maplewood Park P | lace | Bethesda | | Montgomery |
| | Funeral | | | Sex 7. Age (In yrs. last birthda) | Months Days Hours M | | 9. Birthplace (State or Foreign Country) |
| 3 | Director | | 579-28-9948 | 80 Yrs. | | | 1925 Pennsylvania |
| | pur * | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or I | ocation | | 10d. Inside City Limits |
| | eho | ž | 100.000 | | 20041011 | | 1 ☐ Yes 2 ☑ No |
| | 788-f | ect | Maryland Montgo | omery Bethes | | | |
| | with t | ä | 10e. Street and Number | D 7 #0600 | 10f. Zip Code | | Citizen of What Country? |
| | within 72 hours after death with the Maryland ene. then *natural', or iteme 23s or 28s-f ehow ta Madical Exercitor mast be notified at | Funeral Director | 9707 Old Georgeto | | 20814 | | USA |
| | item item | nue | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 36 | or or | by F | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: | 1 ☐ Yes 2 🛣 No Specify: | | Specify: White |
| 5-0036 | hour turai | be | 15. Decedent's E | | edent's Usual Occupation | 166 | Kind of Propagation at a |
| Ú | in 72 | Completed | (Specify only highest gr | ade completed) (Giv | e kind of work done during most of v DO NOT use retired) | vorking | . Kind of Business/Industry |
| 2121 | with ene. | E C | Elementary/Secondary (0-12) | College (1-4or 5+) | memaker | | Own Home |
| ס | Hygi Hygi ther | ပိ | 17. Father's Name (First, Middle, Last | | | lame (First, Middle, Maid | |
| Maryland | d be ental | o Be | Lee McKinstry B | ryan | Gene | vieve Flood | |
| ₹ | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23s or 28s-f ehow any injury or other traumatic event, the Medical Exaction must be notified at anone. | ပ္ | 19a. Informant's Name/Relationship | (Type, Print) - Son 19b. Mai | ling Address (Street and Number or | | ty or Town State Zin Code) |
| <u>≅</u> | id 2 s th ar trau trau | | Augustine B. (Mic | | | | |
| Ġ, | 1 ar Hea Hea Hem | | 20a. Method of Disposition | 20b. Place of Disc | 09 Gatsby Terrac | | ary Land 20832 Location - City or Town, State |
| ē | To E of See | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Themoval from State Cato of Uc | ematory or other place) Noveven Cemetery | mber 8 | |
| altimore, | rtan diu | | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice | (7) | - | 2005 Si | lver Spring, Marylan |
| Ba | Department of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population of the population o | | 21. Signature of Fullerial Service Lice | | 22. Name and Address of Facility Francis J. Colli | ns Funeral | Home Inc. |
| 35- | No. 1 To | | Alones 2 | aplications that caused the death. Do not en | | | ver Spring, MD 20901 |
| 7 | | | shock, or heart failure. List only | one cause on each line. | nter the mode or dying, such as card | lac or respiratory arrest, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | a Respiratory Fail | ure | | Shoot and Boath |
| | /Medical Examiner | | resulting in dealin) | Due to (or as a consequence of): | | | |
| | Lxummer | | Sequentially list conditions, | Chronic Obstruct | ive Lung Disease | | |
| | pe tis | ine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence or): | | | |
| | and tran | Examiner | that initiated events resulting in death) Last | c. | | | |
| ŠÓ, | oe ex | Ē | | Due to (or as a consequence of): | | | 4 |
| 68760, | icate be executed physician and s the burial-transit | edicai | | d | | | |
| | fing p | Me | IF FEMALE: | 00.14 | | | 70 |
| Box | ath c | lan | 23b. Was decedent pregnant in the past 12 months? | | □Ectopic pregnancy | | 23d. Date of delivery Month Day Year |
| <u>.</u> | the a | sic | 1 Yes 2 No | 4□Pregnant at time of death 5 9□ Unknown | Other (specify) | | World Day 16a1 |
| 0. | The law requires that the death certif ite has been signed by the attending rage 2 should be detached for use a | Physician/M | | | | | |
| | signe d be d | by | | contributing to death but not resulting in the | underlying cause given in Part I, | | to use contribute to the cause of death? |
| 010 | w requir been si should | Completed | Chronic Anemia, D | Diabetes Mellitus | | 1 Tes | No 3 Probably 4 Unknown |
| ပိ | elawi hasbu je 2 sh | pie | | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| E | | Ю | | | | performed 1 Yes 2 ☑ | ? death? |
| ta | ysician: The is certificate hi director, page | Bec | 25. Was case referred to medical | | 26. Place of D | eath (Check only one) | |
| Division of Vital Records, | Physic this ce al direc | To | examiner? 1 ☐ Yes 2X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie | ent 3 DOA Other: 4 1x Nursing | Home 5 Residence | 6 ☐ Other (Specify) |
| 0 | ding Ph h. After th funeral | | 27. Manner of Death 1 X Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) 28b. Time | | 28d. Describe how in | |
| 0 | ath. r: After | atic | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio | | M 1 Yes 2 No | | |
| <u>S</u> | or Attending Physician: ifter death. Director: After this certifics in by the funeral director. I | tific | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At home, farm, s building, etc. (Specify) | treet, factory, office | 28f. Location (Street City or Town, St | and Number or Rural Route Number, |
| ā | taio, rsaft al Di | Certification; | | | | J., G. 10mii, 31 | / |
| | pspil hour uner iy filk | | 29a. Certifier (Check only 2 Medical Example 2 | nysician: To the best of my knowledge, dea | th occurred at the time, date and pla | ce, and due to the cause | e(s) and manner as stated. |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medicai | one) | miner: On the basis of examination and/or i and manner stated. | nvestigation, in my opinion, death oc | curred at the time, date a | and place, and due to the cause(s) |
| | with To 1 | Σ | 29b. Signature and title of certifier | | 29c. License number | 29d. l | Date signed (Month, Day, Year) |
| | 17/ | | Merlyn | 1 emurin M | D35791 | No | ovember 10, 2005 |
| | 10 | | 30. Name and address of person who | completed cause of death (Item 23a) (Type | , Print) | | |
| | | | Merlyn Vemury, M | I.D. 9801 Georgia A | venue, #227, Silv | ver Spring, | MD 20902 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32 Aegistrar's Signature | male | | |

| | | | 1 - For State Registrar | State of | Maryland | | artment rtificate | | | Mental Hy | giene Reg. No . | 005 | 38399 |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------|----------------------------------------|----------------------------------------------|------------------------|-------------------------------------------|-----------------------------------------------------|---------------------------|--------------------------------------------|------------------------------------------------------|
| | Physici /Medi | al | Decedent's Name (First, Middle, CAROL Tasilia Name (Kashinsia) | W. | | | | LNER | | 2. Date of De Month NOV 8, | 2005 | Year | 3. Time of Death 12:55 A M |
| | Examir Funeral | er | 4a. Facility Name (If not institution, 5702 BREWER HOU 5. Social Security Number | SE CIRCLE | | ast birthday) | NORTH | BETH Year If | cation of Death HESDA Under 24 Hrs. | | į | | GOMERY |
| Ĭ. | Director | | 217-46-7087 Usual Residence of Decedent | 1□M 2XIF | 6 | 0 Yrs. | | Days F | Hours Min. | 8. Date of Bir (Month, Da MAY 9, | y, Year) 1945 | WA | thplace (State or Foreign buntry) SHINGTON, DC |
| | the Marylad 28a-f show | Director | 10a. State 10b. County MARYLAND MONTGO 10e. Street and Number | MERY | 10c. City | r, Town or Lo | NORTH | | ESDA | | | | 10d. Inside City Limits 1 X Yes 2 No |
| | eath with | eral Dir | 5702 BREWER HOUS | | | 3 140 | 10f. Zip C | 20 | 0852 | | U | on of What Co | |
| 9000 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show entry joury or other treumatic event. I'm Medical Eventine must be notified at ODGE. | d by Funeral | 11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced | 12. Was Decede Armed Force d 1 Tyes 2 If Yes, Give Year or Date | es? Ľ X No | | was Deceder f Yes, specify 1 ☐ Yes 2 ☐ | | | Decify Yes or No Decify Yes or No Decify Yes | | 4. Race - Ame Black, Whit Specify: W | e, etc. HITE |
| 21215-0036 | f within 72 h piene. r then "natu I're Medica | Completed | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | Education grade completed) College (1-4 | or 5+) | (Give life. L | dent's Usual (kind of work DO NOT use | done durir retired) | n ng most of worl | king | | of Business/ | , |
| Maryland ? | uld be filed Mental Hyg arked othe aric event, | To Be C | 17. Father's Name (First, Middle, La BERNARD WOOL | ast) | | | | 18. | . Mother's Nam | ne <i>(First, Middl</i> e, LAZER | | | |
| | and 2 sho ealth and I m 27 Is me | | 19a. Informant's Name/Relationshi DR. BRUCE A. KEL | | | 5702 | BREWER | HOUS | SE CIRC | - | N. | Town, State, Z BETHESI | Zip Code) DA, MD 20852 |
| Baltimore, | t. Pages 1 rtment of H rtant: If ite | | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of | ecify) | ite ce | | MORIAL | GARI | 11/1 | | OL | | Town, State |
| Ba | permit Depar Impor eny in | | 23a. Part I. Enter the disease, or coshock or heart failure. I jet or | Stott | | u10 | 091 RO | CKVII | LE PIK | | /ILLE | INC. , MARY | LAND 20852 |
| | Pnysician /Medical | | shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) | a. BREAST | L CANCE | R | | -73, | | | | | Interval Between Onset and Death 18 YEARS |
| 8760, | cate be executed physician and sthe burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure that initiated events resulting in death) Last | b | as a conseque | ence of): | | | | | | | |
| .O. Box 6 | death certif e attending od for use as | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | 2 Fetal of at time of dea | death 3 🗌 | Ectopic pregi Other (speci | | | | 23 | d. Date of deli | very Day Year |
| rds, P. | quires that en signed b uld be det | by | Part II. Other significant condition | s contributing to death | n but not resul | iting in the un | derlying caus | e given in | Part I. | | bacco use | | the cause of death? |
| Vital Record | : The law requires that the cate has been signed by th page 2 should be detache | Completed | | | | | | | | 24a. Was a autop perfor 1 🗆 Yes | sy me <u>d?</u> | prior to c death? | topsy findings available ompletion of cause of |
| oţ | Attending Physicien: Thir death. actor: After this certificate by the funeral director, pag | ation: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investiga | 28a. Date of Ir (Month, I | atient 2 Enjury Day Year) | R/Outpatient 28b. Time of Injury | | - | 1 Nursing Ho | h (Check only or me 5 X Resid 28d. Describe h | ence 6[| | ify) |
| Divis | ital or Attendrs after death al Diractor; led in by the | Certification: | 3 Suicide 6 Could no 4 Homicide determin | ad 28e. Place of | Injury - At hom etc. (Specify) | ne, farm, stre | et, factory, o | fice | | 28f. Location (S City or Tow | | Number or Rui | ral Route Number, |
| | To the Hospital or A within 24 hours after To the Funeral Dira completely filled in b | Medical | one) | Physician: To the be eminer: On the basis and manner | of examination | tedge, death on and/or inv | estigation, in | my opinio | n, death occurr | ed at the time, d | ate and pl | ace, and due | to the cause(s) |
|) | T wit | | 29b. Signature and title of certifier | Cayles | mus | A | D. | 54078 | | 1.1 | | BER 9, | |
| | 12 | | 30. Name and address of persor() At CHERYL A. AYLESW 31. Date filed (Month, Day, Year) | ORTH, ⁰ M.D. | 6410 | ROCKLI | | RIVE, | SUITE | 506, BE | THESI | DA, MD | 20817 |
| | Sta Registr | | | 2005 | strar's Signatu | K do | ule | | | | | | |

| _ | | | | For State | State of Maryla | | artment of F | Health and | Mental Hy | gien | °005 | 384 | 00 |
|---------|-----------|--------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------|---------------------------------------|------------------------------------|-----------|---------------------------------|---------------------------------------|----------------------|
| | | | | Registra MEND#19a, perFF 1. Decedent's Name (First, Middle, Las. | | to ce | runcate or | Deam | 2. Date of De | | | 3. Time o | of Death |
| | | Physici /Medic | | Daniel K. Kohl | neier | | | | Month Novembe | er 6 | y Year 2005 | 4:30 | Амд |
| | | Examin | | 4a. Facility Name (If not institution, give | • | | | or Location of Deat | | | . County of Dea | th | |
| | | Formul | | Suburban Hospit 5. Social Security Number 6. Se | | rs. last birthday | Bethesd If Under 1 Year | | 8. Date of Bir | th | ontgome | _ | or Foreign |
| | | Funeral Director | | | MM 2□F 45 | Yrs. | Months Days | Hours Min. | (Month, Da | ıy, Year, | | thplace (State ountry) SSOUTÍ | or r oreign |
| | | and w.w. | | Usual Residence of Decedent 10a. State 10b. County | 10c. | City, Town or L | ocation | | | | | 10d. Inside (| ity Limits |
| | | ours after death with the Marylan et', or Items 23e or 28e-f show Examirer , ust be nutified at | ţō | Maryland Montgome | | Bethese | | | | | | | 2 □ No |
| | | ith the M or 28e-f | Director | 10e. Street and Number | <u> </u> | betnesc | 10f. Zip Code | | | 10g. Ci | tizen of What Co | ountry? | |
| | | ath wi | rai | 7500 Woodmount Av | | | 20814 | | | | .S.A. | | |
| 12 | 10 | or Items | Funerai | 11. Marital Status 1 X Never Married 2 Married | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No | | Was Decedent of H If Yes, specify Cuba | | pecify Yes or No o Rican, etc.) |)- | 14. Race - Ame Black, Whit | | |
| 11-6-05 | 5-0036 | | þ | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2X No | Specify: | | | Specify: Wh | nite | |
| 1 | 5-0 | "neturel", | Completed | 15. Decedent's Edi (Specify only highest grad | ication le completed) | 16a. Dece (Give | dent's Usual Occup kind of work done DO NOT use retired | pation during most of wo | rking | 16b. K | (ind of Business | Industry | |
| 1 | 2121 | within ene. then | dmc | Elementary/Secondary (0-12) | College (1-4or 5+) 4 | | edule Tecl | | | Cabi | le Telev | ricion | |
| AM | b | should be filed within 72 hound Mental Hygiene. s marked other then "netuumatic event, it e Medical | Be C | 17. Father's Name (First, Middle, Last) | | Deire | dare rec | | me (First, Middle, | | | 151011 | |
| 0 | ylaı | 2 should be f and Mental Is Is marked of eumatic eve | ToE | Louis Kohlmeier | | | į | Barbara | a Wilson | | | | |
| is | Maryland | tre tre | | 19a. Informant's Name/Relationship (T | | Paramaters. | ng Address (Street | | | . 6. | | | |
| 3 | | s 1 and 3 of Health ltem 27 other tr | | Louis Kohlmeier/Fo | | . Place of Dispo | Strand | | 105 Roc Date | 20c. L | ocation - City or | ryland Town, State | 20852 |
| | Ë | Pages nent of ant: If I | | 1 ☐ Burial 2X Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, | | - | matory or other place t Cremate | | 8,2005 | Alex | andria. | Va. | |
| 50 | Baltimore | permit, Pages 1 and Department of Heali Importent: If Item 2 eny injury or other once. | | 21. Signature of Funeral Service Licens | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | 2. Name and Addre | | | | | | |
| 0 | ш | 20599 | | William K. | Pregy | | 130 Wisco | | | | 1.D.C. 2 | | |
| 9 | | . | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final | ne cause on each line. | | | | | rrest, | | Approxima Interval Be Onset and | ween |
| 1 | | Physician /Medical | | disease or condition resulting in death) | a. CEVENTO Due to (or as a cons | | nar a | caaa | 15 | | | | |
| | ш | Examiner | | Sequentially list conditions. | b | | | | | | | | |
| 34 | | ed sit | niner | Sequentially list conditions, if any, leading to minimum solutions cause. Enter Underlying Cause (Disease or injury | Due to (or as a cons | aquence of j. | | | | | | | |
| 3 | ς, | sician and burial-transit | Examiner | that initiated events resulting in death) Last | c Due to (or as a cons | equence of): | <u> </u> | | | | | | |
| 0 | 8760 | ate be executed hysician and the burial-transit | dicai | | d | | | | | | | | |
| | 39 x | | Med | IF FEMALE: | 20-16 | | | · · · · · · · · · · · · · · · · · · · | | | | | |
| 5 | Bo | death certific e attending pl ed for use as t | by Physician/Med | in the past 12 months? | 23c. If yes, outcome of preg 1□Live birth 2□Fe 4□Pregnant at time o | etal death 3 | Ectopic pregnancy Other (specify) | ′ | | | 23d. Date of del Month | , | Year |
| 8 | Ö. | 0 0 2 | hysi | 1 □ Yes 2 □ No 9 □ Unknown | 9□ Unknown | | // | | | | | | |
| بسا | S, F | es the gned be de | | Part II. Other significant conditions co | ntributing to death but not r | esulting in the u | nderlying cause give | en in Part I. | Ì | | use contribute to | | e l |
| 1 | ord | w requir been si should | eted | | | | | | - | res 2 | □No 3□Pr | obably 4 | Jaknown |
| 0 | Rec | The law ate has b page 2 s | Completed | | | | | | 24a. Was autop perfo | | 24b. Were au prior to death? | topsy findings completion of a | available ause of |
| 2 | ta | | O | 25. Was case referred to medical | | | | 26. Place of Dea | 1 Tyes | 2 No | | 2 No | |
| Ś | Ϋ́ | di ib | To B | examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) | Hospital: 1 Inpatient 2 | ☐ ER/Outpatier | t 3 DOA Oth | er: 4 Nursing H | | | 6 ☐Other (Spec | cify) | 5.57 |
| _ | o uo | ding Ph h. After thi funeral | | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injun Worl | y at k? | 28d. Describe h | | | | |
| 2 | ision | Attendi death. ctor: A y the fu | ficat | 2 Accident investigation 3 Suicide 6 Could not be | 28e. Place of Injury - At | home, farm, str | | Yes 2 □No | 28f. Location /5 | Street an | nd Number or Ru | ral Route Num | her |
| 9 | Βį | spitel or Att ours after de lerel Directi filled in by t | Certification: | 4 Homicide determined | building, etc. (Spe | cify) | out, ractory, cinice | | City or Ton | vn, State |) | 747 10016 14017 | ber, |
| | | Hospitel or Attending 24 hours after death. Eunerel Director: After ietely filled in by the fune | edical (| 29a. Certifier (Check only) Certifying Phy Medical Exami | sician: To the best of my k | nowledge, death | occurred at the time | ne, date and place | , and due to the | cause(s) | and manner as | stated. | 4 |
| | | To the Hos within 24 ho To the Fun completely f | Medi | one) 29b. Signature and title of certifier | and manner stated. | | 29c, License | | | | te signed (Month | · · · · · · · · · · · · · · · · · · · | |
| | | ₹ ½ ₹ % | | NULlan | hun. | | (07 | 2949 | ' | 11 | 1610 | 5 | |
| | | 6 | | 30. Name and address of person who | muleted cause of death (It | em 23a) (Type, | Print) 8600 C | old Georg | etown Ro | i | Bethesd: | a. MD | 20814 |
| | | | | Natasna | Hades | | | | | | | | |
| | | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registrar's Sig | nature | marke) | | | | | | |

| | | | 1 - For State Registrar | State of Ma | ryland / | | artment tificate | | | and Me | | giene Reg. No. | 05 | 3841 | 0 1 |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------|--------------------------|-----------------------------------------------------|-------------------------------------|-----------------------------------------|---------------------------|-----------------------------------------|----------------------------|-----------------------------------------------------------|---------------------------------------|----------------------|
| I | Physici /Medic | | 1. Decedent's Name (First, Middle, L Helen Lore | | r | | | | | | 2. Date of De Month Novembe | er 11 | , 2005 | 3. Time of 10:30 | Death P M |
| | Examir | | 4a. Facility Name (If not institution, gi Moran Manor Nu | ve street and number) | e | | | | Location o | f Death | | 4c. C | ounty of Death | | |
| | Funeral Director | | | Sex 7. Age 1 □ M 2 🖾 F 8. | (In yrs. last 4 | birthday) Yrs. | If Under Months | 1 Year Days | If Under a | Min | B. Date of Bird (Month, Da Peb. 8 | th ly, Year) | 9. Birth | nplace (State of untry) Land | r Foreign |
| | ryland how | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | | | | | | | | | 10d. Inside Ci | |
| | the Ma | recto | MD. Allega | iny | Wes | tern | port 10f. Zip | Code | | | | 10g. Citize | en of What Co | MXYes untry? | 2 No |
| | ath with s 23a or | raj Di | 313 Spruce | st. | | | | 2156 | | | | | ted Sta | | |
| 9800 | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 23e-f show other treumatic event, I've Medical Examiliar interinal be indiffied at | d by Funeral Director | 11. Marital Status 1 Never Married 27 Married 3 Widowed 4 Divorced | 12. Was Decedent & Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates: | | | Vas Decede f Yes, speci | | spanic Orig , Mexican Specify: | gin? (Spec , Puerto Ri | ify Yes or No ican, etc.) | | i. Race - Amer Black, White Specify: W | | |
| 21215-0036 | filed within 72 h Hygiene. Other then "natuent, "te wedien | Completed | 15. Decedent's 8 (Specify only highest g. Elementary/Secondary (0-12) unknown | ducation ade completed) College (1-4or 5- | | (Give life. L | tent's Usual kind of work DO NOT use Clerk | l Occupa k done di e retired) | tion u <i>ring m</i> ost | of working | 7 | | of Business/l rtment | ŕ | |
| Maryland | 2 should be filed and Mental Hygie is marked other eumatic event, III | To Be C | 17. Father's Name (First, Middle, Las Elmer Russe | | 1 | | | | 18. Mothe Rut | | First, Middle, aster | | umame) dwater | - | |
| | 1 and 2 sho Health and Iem 27 is m | | 19a. Informant's Name/Relationship Kenneth Keller/ | | | | | | | | port, I | | Town, State, Z and 21 | ip Code) 562 | |
| Baltimore, | 9 = 5 | | 20a. Method of Disposition DEBurial 2 Cremation 3 Cremation 5 Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control | | ceme | tery, cren | sition (Nam natory or oti emete: | her place |) | 11/15 2005 | ^{te} / | | ation - City or T ernport | own, State Maryl | and |
| Balt | permit. Pa Departmer Importent: any Injury once. | | 21. Signature of Funeral Service Lice | ne Sa | l | 1 | 11 Ch | urch | St, | Weste | | t, Ma | ome ryland | 21562 | |
| | rnysician /Medical Examiner | 16 | 23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. | one cause on each lin | e. nn8 a consequence | ce of): | | , , | | | H IIV | | >×ss | Approximate Interval Bett Onset and D | ween |
| 8760, | ate be executed thysician and the burial-transit | licai Examine | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a | | | | | | | | | | | |
| O. Box 6 | The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown | 23c. If yes, outcome of 1 □ Live birth of 4 □ Pregnant at 9 □ Unknown | 2 🗌 Fetal dea | ath 3 🗆 | Ectopic pre | egnancy ecify) | | | | 23 | d. Date of deli Month | , | 'ear |
| rds, P. | w requires that been signed b should be deta | þ | Part II. Other significant conditions | contributing to death bu | it not resulting | g in the ur | nderlying ca | use give | n in Part I. | | | obacco use Yes 2 🗆 | | the cause of di | eath? |
| Vital Records, | | Completed | | | | | | | | | | | 24b. Were aut prior to co death? 1 \(\text{Yes} | opsy findings a completion of ca | ivailable luse of |
| Vita | Physicien: Th this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | nt 2□ER/ | Outpatien | t 3 🗆 DO/ | Otho | | | Check only o | 44 | ☐Other (Spec | ify) | |
| ion of | ling After une | ation; T | 27. Manner of Death Natural 5 Pending Z Accident investigation | 28a. Date of Injur (Month, Day | y 28t | o. Time of Injury | | c. Injury Work | | 28 | d. Describe h | | | .,,, | |
| Division | i Site | Certification; | 3 Suicide 6 Could not 4 Homicide determined | | ry - At home, . (Specify) | farm, stre | eet, factory, | office | *************************************** | 28 | f. Location (S City or Tow | Street and I vn, State) | Number or Rui | al Route Numi | per, |
| | To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by | edical (| 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa | hysician: To the best of miner: On the basis of and manner sta | examination | ige, death and/or inv | occurred a restigation, | it the time in my opi | e, date and inion, deat | d place, an h occurred | d due to the d at the time, d | cause(s) ar date and p | nd manner as lace, and due | stated. to the cause(s) | |
| | To the within To the comp | Me | 29b. Signature and title of certifier | | | | | License | | | | | signed (Month | | |
| , | | | 30. Name and address of person who | completed cause of de | eath (Item 23a | a) (Type. I | | D2 | 124 | lef. | 95 | 11 | 114/0 | 2005 | |
| | | | DR. JESUS TAN | 10701 NEV | GEORG | GES C | | RD. | FROS | TBURG | , MD | 21532 | 2 | | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | 2005 32. Registra | r's Signature | | Contille . | 9 | | | | | | | |

Registrar

| | | | 1 - For Stete Registrar | State of Marylar | nd / Depa | artment of F | lealth and Death | | giene Reg. No. | 005 | 38403 |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------|--------------------------|---------------------------------|--------------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle, Last | , | | | | 2. Date of De | | Year | 3. Time of Death |
| | /Medic | al | RUBY THOMAS | | | 4h Cihi Taura | al antine of Da | OCT. | | 2005 County of Dea | 2:05 P M |
| | Examir | er | 4a. Facility Name (If not institution, give Sligo Creek I | | ehah | | or Location of Dea | | 1 | ONTGO! | |
| | Funeral | | 5. Social Security Number 6. Se | x 7. Age (In yrs. | | _ If Under 1 Year | If Under 24 Hr | rs. 8 Date of Birt | th | | |
| | Director | | 216-22-0151 | Z ^{M 2□ F} 78 | Yrs. | Months Days | Hours Min | m. May 1, | 19 | 27 | thplace (State or Foreign cunity) Maryland |
| | pu 🛊 😅 | | Usual Residence of Decedent 10a. State 10b. County | 10c Ci | tv. Town or Lo | ocation | | | | | 10d. Inside City Limits |
| | Aaryla F sho | ō | , | gomery | _ | coma Pai | rk | | | | 1 Xes 2 No |
| | the 28a- | rect | 10e. Street and Number | JOINEL Y | | 10f. Zip Code | C 17 | | 10g. Citi: | zen of What Co | ountry? |
| | h with | Funeral Director | 7525 Carroll | Avenue | | | 20912 | | | U.S.A | - |
| | death | ner | 11. Marital Status | 12. Was Decedent Ever in U Armed Forces? | .S. 13. | Was Decedent of H | Hispanic Origin? | (Specify Yes or No- erto Rican, etc.) | - | 14. Race - Ame Black, Whit | |
| 36 | or its | | 1 Never Married 2 Married | 1 ☐ Yes 2 ☐Ño If Yes, Give | | 1 ☐ Yes 2 🛣 No | | sito i iloan, etc., | | | Black |
| 21215-0036 | 72 hours after death with the Maryland natural', or itams 23a or 28a-f show disal Exat a writinal be incilled at | ed by | 3 Widowed 4 Divorced | Year or Dates: | 160 Door | doatio Ulavel Conve | | | | | |
| 15 | in 72 | olete | 15. Decedent's Edu (Specify only highest grad | de completed) | (Give | dent's Usual Occup kind of work done DO NOT use retire | during most of w | rorking | 16b. Kir | nd of Business | Industry |
| 212 | d with piene. | Completed | Elementary/Secondary (0-12) 9th | College (1-4or 5+) | | halt W | | | Co | nstru | ction Co |
| ٦ | e filec al Hyg othe vant, | | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | ame (First, Middle, | Maiden | Sumame) | |
| Jai | Menta | To Be | William Lar: | ry | | | | Ola Mar | | | |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylam Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury of other traumatic event, the Medical Exact it art must be rediffied and once. | | 19a. Informant's Name/Relationship (T) | | | | | Rural Route Numbe | | | |
| e) | 1 and Health Im 27 | | Viola Larry (\) 20a. Method of Disposition | | | esition (Name of | ST., F | Rockvill | | | |
| Baltimore, | Se in a second | | 1 Burial 2 ☐ Cremation 3 ☐ F | Removal from State | cemetery, crei | natory or other pla | | | | cation - City or | |
| 퍒 | lit. Partmentantant | | '4 □ Donation 5 □ Other (Specify | | | n Mem Pa | | | | kville | HOME, P.A. |
| Ba | Department any i | | FROMG 1. | Alleron | - 40 | | | Rock | | | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | lications that caused the deat | | | | | | | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Final disease or condition | a Cardio- | וחשנות | nary Ari | rest | | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a conseq | | idly iii | | | | | |
| h | Examiner | | Sequentially list conditions, | Metasta | | ing Can | cer | | | | |
| | ed isi | Examiner | Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a nonsec | ulanda orjii | | | | | | |
| | xecut and | хап | that initiated events resulting in death) Last | c Due to (or as a conseq | uence of): | | | | | | |
| 8760, | ate be executed hysician and the burial-transit | alE | | d | | | | | | | |
| 68 | ifficate g physias the | Physician/Medical | | | | | | | | | |
| Вох | death certific e attending p d for use as f | M/UE | 23b. was decedent pregnant | 23c. If yes, outcome of pregna 1□Live birth 2□Feta | | Ectopic pregnancy | | | 2 | 3d. Date of del | ivery |
| | | sicia | in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \) | 4□Pregnant at time of d 9□Unknown | | Other (specify) | <u> </u> | | | Month | Day Year |
| P.0 | by trac | Phy | 9 Unknown | | ulting in the | | es is Deat | 220 Did to | -b | no nontributo to | the sever of death? |
| | | by | Part II. Other significant conditions co | intributing to death but not res | ulling in the u | ndenying cause giv | en in Part I. | | | | o the cause of death? |
| Vital Records, | The law requires ate has been sign bage 2 should be | Completed | | | | | | | | | |
| Rec | ne lay has ge 2 a | mpi | | | | | | 24a. Was autop | | prior to death? | itopsy findings available completion of cause of |
| la | | e Co | 25. Was case referred to medical | | | | De Place of De | | 2√2 No | 1 ☐ Yes | 2 No |
| > | S 0 D | To B | examiner? | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatier | t 3 DOA Oth | or | eath (Check only of Home 5 Resid | | □Other (Soe | cify) |
| ο r | g Ph ter thi | | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of | | | 28d. Describe h | | | 5.17) |
| Sior | ttandin death. ctor: Af y the fur | atic | 1X Natural 5 Pending 2 Accident investigation | (, ==,, | ,, | | Yes 2 □ No | | | | |
| Division | or Att | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At he building, etc. (Specif. | ome, farm, str | eet, factory, office | | 28f. Location (S City or Tow | Street and vn, State) | Number or Ru | ural Route Number, |
| | To tha Mospital or Attanding Phywithin 24 hours after death. To tha Funaral Director: After thi completely filled in by the funeral | | 20a Codilias | delen Territoria | | | | 1 | | | <u> </u> |
| | a Hospital 24 hours a Funaral letely filled | edical | 29a. Certifier Certifying Phy (Check only one) Medicel Exemi | sicien: To the best of my kno iner: On the basis of examina and manner stated. | tion and/or in | occurred at the tire of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the st | ne, date and place pinion, death occ | ce, and due to the courred at the time, o | cause(s) : date and | and manner as place, and due | stated. to the cause(s) |
| | To tha within 2. To tha complet | Med | 29b. Signature and this of certifie | and not stated. | | 29c. Licens | e number | 2 | | signed (Mont) | |
|) | r s r ō | | | 7 - | | | 56147 | | | Oct. | 31, 2005 |
| | 4 | | 30. Name and address of person who co | ompleted cause of death (Item | n 23a) (Type, | Print) | | | | | |
| | | | Nasreen Kango | * | | roll Av | e., Tak | coma Par | ck, | MD 209 | 912 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32 Registrar's Signa | iture | whi. | | | | | |

| | | | For State Registrar | State of Ma | | epartme Certifica | | | Mental Hy | giene Reg. No. | 005 | 38404 |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------|--------------------------------|-----------------------------------|---------------------------------------|-----------------------------------------|----------------------|---------------------------------|-------------------------------|
| | Physicia | | Decedent's Name (First, Middle, Julia Bernae | | owell | | | | 2. Date of De Month Novemb | er 3 | , 2005° | 3. Time of Death 3:00 P M |
| ı | /Medic Examin | | 4a. Facility Name (If not institution, | give street and number) | | | | Location of Dea | | 4c. | County of Deat | 1 |
| | Funeral | | 3128 Gracefield 5. Social Security Number 6 | S. Sex 7. Age | 9 (In yrs. last birth | | lver S | pring If Under 24 Hrs | 8. Date of Bi | rth | ontgome 9. Birtl | ry place (State or Foreign |
| | Director | | 079-26-4756 | 1□M 2 ĕ F | 76 ^Y | Month | ns Days | Hours Min | | 3, 192 | 29 New | York |
| | land | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | | | 10d. Inside City Limits |
| | e Many la-f sh | ctor | Maryland Montgo | mery | Silver | Spri | ng | | | | | 1 ☐ Yes 2 HNo |
| | with th a or 28 | Funeral Director | 10e. Street and Number 3128 Gracefield | Road Apt 20 | 19 | 10f. | Zip Code 209 | 04 | | 10g. Citi. | zen <i>o</i> f What Co USA | untry? |
| | death | nera | 11. Marital Status | 12. Was Decedent 8 Amed Forces? | | 13. Was De | cedent of His | | Specify Yes or No |)- | 14. Race - Ame | |
| 36 | be filed within 72 hours after death with the Maryland ital Hygiene id other than "natural", or Items 23a or 28a-f show event, Ital Marical Exacilier meat ternellihod at | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | | 10 | | pecify Cubar 2 [™] No | Specify: | no Alcan, etc.) | | Specify: Wh | |
| 21215-003 | 72 hou natura lical E | eted | 15. Decedent's (Specify only highest | Education | | ecedent's U | | tion uring most of wo | ndring | | nd of Business/I | |
| 121 | filed within 72 h I Hygiene. other than "nateent, II e Malle. | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | +) | life. DO NO | Tuse retired) | aning most of we | , and | 0 | | |
| 1d 2 | i Hygie Other i | Be Co | 17. Father's Name (First, Middle, La | ast) | HOI | ne Mak | | 18. Mother's Na | me (First, Middle | | Name (Sumame) | |
| Maryland | should be ind Mental e marked o umatic eve | To B | Ferdinand Wiener | | | | | Margare | t Hurley | <i>y</i> | | |
| Mar | d 2 sho th and t7 ie my traumy | | 19a. Informant's Name/Relationship Joseph W Lowell | | | - | | | ura <i>l Route Numb</i> Apt 209; S | | | |
| | permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 le marke any injury emiter traumatic once. | | 20a. Method of Disposition | | 20b. Place of D | Disposition (| Vame of | | Date | | cation - City or | |
| altimore, | Pages Iment of I tant: If its | | 1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe | ecify) | Crowns Vetera | ns Cem | etery | | /8/2005 | Crow | nsville | , Maryland |
| Bal | permit. Page Department I Important: If any injury | | 21. Signature of Funeral Service Li | 5. Wholes | | | and Address | Н | ines-Rin | | | |
| | | | 23a. Part1. Enter the disease, or conshock, or heart failure. List or | omplications that caused | the death. Do no | | | | | | er spri | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Final disease or condition resulting in death) | _aAdvanced | | son's | Diseas | se | | | | Onset and Death 3 Months |
| ı | /Medical Examiner | | resulting in dealth) | Due to (or as a | a consequence of |): | | | | | | |
| | D == | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a | a consequence of |): | | | | | | |
| | xecute and it-trans | Examin | that initiated events resulting in death) Last | c. Due to (or as a | a consequence of |); | | | | | | |
| 8760 | cate be executed physician and the burial-transit | dicalE | | d. | | | | | | | | |
| 9 | | | IF FEMALE: | 020 Huma outcome | -1 -1 | | | | | - 1 | | |
| ВОХ | death certifi e attending od for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No | 23c. If yes, outcome of 1 □ Live birth 1 □ Pregnant at | 2 Fetal death | 3 ☐Ectopic 5 ☐ Other | | | | 2 | 23d. Date of deli- Month | very Day Year |
| J. | at the de by the a | hys | 9 Unknown | 9□ Unknown | | | | | | | | |
| | The law requires that the te has been signed by thoage 2 should be detache | by | Part II. Other significant condition | s contributing to death bu | ut not resulting in t | he underlyin | g cause give | n in Part I. | | _ | _ | the cause of death? |
| Records, | w require s been sly should b | ietec | | | | | | | 24a. Was | | | opsy findings available |
| | | Completed | | | | · | | | auto perfo | ormed? | death? | ompletion of cause of 2XNo |
| VIta | iclen: certific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | DOA Other | | ath (Check only | | | |
| ō | ding Phys h. After this funeral dir | n: To | 1 ☐ Yes 2 ☒ No 27. Manner of Death | 1 ☐ Inpatier 28a. Date of Injur (Month, Day | y 28b. Tir | ne of | 28c. Injury Work | 4 Nursing i | dome 5 X Resi 28d. Describe | | | ıfy) |
| Sion | eath. or: Aft | catio | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no | tion | | М | 1 🗆 Y | es 2 No | | | | |
| Division of Vital | or Att after d Direct I in by | Certification; | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | | ury · At home, fam c. (Specify) | n, street, fact | ory, office | | 28f. Location (City or To | | | al Route Number, |
| | To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu | edicai C | 29a. Certifier 1 | Physicien: To the best of caminer: On the basis of and manner sta | examination and/ | death occurr or investigati | ed at the time ion, in my opi | e, date and place inion, death occ | e, and due to the urred at the time. | cause(s) date and | and manner as place, and due | stated. to the cause(s) |
| | To th withir To th comp | Me | 29b. Signature and title of certifier | D. K | 1 | | 29c. License | | | | e signed (Month | |
| | 12 | | | Puthume | , | 10 | | 1524 | | Nov | - ' ' | |
| | | | 30. Name and address of person who LOVEEN J. PUT! | OCCUMPLET CAUSE OF DE | BIID GRA | CEFI | ELD RI | DAD, SI | LVERSP | RINE | a, MD | 20904 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registra | ar's Signature | Board | | | | | | |

| 0 | | | 1 - For State Registrar | State of Mary | | artment of He rtificate of E | | | giene 005 | 38405 |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------|-----------------------------------------|-----------------------------------|----------------------------------------------|----------------------------------------------------|
| | Physic | | 1. Decedent's Name <i>(First, Middle, La</i> Jeffrey K. L | - | | | | 2. Date of Dea Month NOVEMB | Day Yea | |
| | /Medi Examii | | 4a. Facility Name (If not institution, give | | | 4b. City, Town, or I | Location of Death | TACATATA | 4c. County of De | |
| | | | ANNE ARUNDEL MEI | ICAL CENTER | | ANNAPOL | IS | | ANNE AR | UNDEL CO |
| | Funeral | | Social Security Number 6. 5 | | yrs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day | | Birthplace (State or Foreign Country) |
| AC . | Director | | 371-70-8667 | 1 ⊠ M 2□ F | 49 Yrs. | Months Days | FIOUIS IVIII. | May 15, | 1956 | MI |
| | pur * | | Usual Residence of Decedent 10a. State 10b. County | 10 | c. City, Town or Lo | ocation | | | | |
| | Aaryli aho | ō | , | Arundel | o. o.ly, rown or Lo | | o Donale | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | 28a-1 | Director | 10e, Street and Number | ar mider | | Severn | a Park | | | |
| | death with the Maryland ms 23a or 28a-f show Imust be notified at | 급 | 6 Emerson Road | | | | 1.0 | 1 | log. Citizen of What | • |
| | leath | era | 11. Marital Status | 12. Was Decedent Eve | rin U.S. 13 V | 211 | | acty Vac or No. | US | nerican Indian. |
| Maryland 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, the Machael Examinar must be notified at | by Funeral | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | Was Decedent of His If Yes, specify Cuban 1 □ Yes 2☑ No | Specify: | Rican, etc.) | | |
| 5-0 | 72 h | Completed | 15. Decedent's E (Specify only highest gra | ducation ade completed) | 16a. Deced | dent's Usual Occupat kind of work done du | ion | ina | 16b. Kind of Busines | ss/Industry |
| 21 | of thin | du | Elementary/Secondary (0-12) | College (1-4or 5+) | life. I | DO NOT use retired) | | ,,,9 | Do:11 0 | |
| 2 | e filed within al Hygiene. I other than " | | 47 Estada Navi (Final Adia) | 2 | Ge | neral Man | | | | weeping, Inc. |
| anc | ould be fi Mental H arkad ot atic ever | Be | 17. Father's Name (First, Middle, Last, James K. Lontz | | | 1 | | | Maiden Sumame) | |
| Ž | id 2 should be ith and Mental 27 is markad o traumatic eve | 40 | 19a. Informant's Name/Relationship (| Turna Brintl | 10h Maille | Add (ChA | Rhoda Vo | | | |
| Ma | d 2 s th an th an trau | | | | | | | | r, City or Town, State | , Zip Code) |
| | Health to tom 27 I | | Patricia H. Lont 20a. Method of Disposition | | Ob. Place of Dispo | merson Roasistion (Name of | | rna Park | MD 211 20c. Location - City of | |
| ΘĽ | ages ant of it: If ii | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | Removal from State | cemetery, cren | natory or other place) | 21018 | 11, | Baltimor | • |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other Once. | 1 | 21. Signature of Funeral Service Licer | | 22 | Name and Address | of Equilibr | - | | |
| Ä | Departi Departi Importi eny inji | | 23a. Part1. Enter the disease, or com | Sun | B 4 | arranco & 95 Gov. R | Sons, P itchie H | .A. Seve wy, Seve | erna Park erna Park, | Funeral Home MD 21146 |
| | Physician /Medical Examiner | Examiner | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a co | | le I | June | 4 | | Approximate Interval Between Onset and Death |
| P.O. Box 68760, | The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medical Exa | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | Due to (or as a co | regnancy Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of d Month | elivery Day Year |
| Records, F | uires tha signed Id be de | by | Part II. Other significant conditions of | ontributing to death but no | t resulting in the un | derlying cause given | in Part I. | 23e. Did tob | N | to the cause of death? |
| Ö | w requires been si | lete | | | | | | 24a. Was ar | 24h Word | autopsy findings available |
| | | Completed | 05 W. | | | | | autopsy perform Yes 2 | y prior to ned? eath? | completion of cause of |
| Vital | | o Be | 25. Was case referred to medical examiner? 1X Yes 2□ No | Hospital: | | 104 | 6. Place of Death | | | |
| ō | Phys rthis raldi | H-1 | 27. Manner of Death | 1 ☐ Inpatient 28a. Qate of Injury | 2 ER/Outpatient | SALIDOA | | | nce 6 Other (Sp | ecify) |
| Division | To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Attencompletely filled in by the funeral Director. | Certification: | 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined | Month/Day Yes | At home, farm, stre | 28c. Injury a Work? M 1 □ Ye et, factory, office | s al No | river i | NVeful | Rural Route Number. |
| | Hospitat or 24 hours afte Funeral Dire etely filled in b | Medical | 29a. Certifier (Check only one) 1 Certifying Ph | ysicien: To the best of my liner: On the basis of exa- and manner stated. | knowledge, death mination and/or inv | occurred at the time, estigation, in my opin | date and place, a ion, death occurre | and due to the ca | use(s) and manner a ite and place, and du | as stated. le to the cause(s) |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | A - | | 29c. License n | | | 9d. Date signed (Mon | |
| | | | () / / we h | CIMI | | O C M | E | N | NOVEMBER 8 | , 2005 |
| | | | 3 N and alydrogs of berson who | completed cause of death | (Item 23a) (Type, F | | | | | |
| | | | U. Utton (| DUKE AN |) | 111 PENN | STREET, | BALTIMOF | RE, MARYLA | ND, 21201 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | degistrar's S | Signature | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 8, **Physician** 2005 Long 1:00 АМ Sammie L. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Larkin Chase Nursing Home Bowie Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 5,1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K 425-24-7354 83 Director Yrs Alabama Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Mudical Examiner must be notified at Director Prince Georges Bowie 1 Yes 2 □ No 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after deeth with 11 Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural; or items 23a or 2, ether any injury or other treumatic event, the Mudical Examination 200. 10f. Zip Code 10g. Citizen of What Country? 12008 Tempo Lane 20715 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Clifford Shyrigh Gladys Magdelene Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lyons/ Daughter 12008 Tempo Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 11/11/2005 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licen 16000 Annapolis Road Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aidiac **Physician** /Medical Due to (or as a consequence of): Examiner lue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) to the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 □Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 tonknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate hes page 2 s autopsy performed certificate 2□ No 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 1 Yes 2 No ٩ Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Natural 5 Pending investigation Injury death. i Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter of To the Funersi Direct mpletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name address of son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State NOV 1 Registrar 0 2005

DHMH 17 Rev 1/2001

ORIGINAL

| | | | 1 - For State Registrar | State of M | | ertificate of De | | ental Hygie | CUUS | 38407 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------|---------------------------------------------------|----------------------------------------------------|
| | Physici | | Decedent's Name (First, Middle, Last, Jean Loughery |) | | | | 2. Date of Death October | 30°, 200°5° | 3. Time of Death 2:30 p M |
| • | /Medic Examin | | 4a. Facility Name (If not institution, give Shady Grove Adven | street and number tist Hosp | pital | 4b. City, Town, or Loc Rockville | ation of Death | <u> </u> | 4c. County of Death | |
| | Funeral Director | | 5. Social Security Number 6. Se 402-22-7848 | х Эм 24ДF 82 | nge (In yrs. last birthda) Yrs. | | ours Min. | 8. Date of Birth (Month, Day, Ye | 9. Birth Cou 1923 Kent | |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or I | ocation | | | | 10d. Inside City Limits |
| | e Mary | ctor | Maryland Montgomer | У | Derwood | | | | | 1 ☐ Yes 3 No |
| | th with the 23a or 28 | ai Dire | 10e. Street and Number 7629 Miller Fall | Road | | 10f. Zip Code 20855 | | | Citizen of What Cou Lted State: | • |
| 9036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any ilury or other traumatic event, I're Madical Exartinar must be notified at another. | Completed by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates: | No i | . Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 ☐ No Sp | nic Origin? (Spec lexican, Puerto P pecify: | oify Yes or No- lican, etc.) | 14. Race - Ameri Black, White, Specify: Whi | etc. |
| Maryland 21215-0036 | vithin 72 h ne. han "natu e Medice. | mpiete | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | | (Giv | edent's Usual Occupation e kind of work done during DO NOT use retired) | g most of workin | g | b. Kind of Business/Ir n Home | dustry |
| d 21 | filed w Hygiel other ti | Be Co | 12 17. Father's Name (First, Middle, Last) | | Homen | 18. | Mother's Name | (First Middle Ma | iden Sumame) | |
| ylan | Suld be Mental arked a | To B | Robert H. Burger | | | Ма | rgaret ^E | lizabeth | Brown | |
| Mar | and 2 shi ealth and n 27 is m | | 19a. Informant's Name/Relationship (T) David Loughery/Son | vpe, Print) N | 19b. Mai 1521 | ling Address (Street and I 5 Water Oak | Drive, | Route Number, C Gaithers | ity or Town, State, Zip burg, Mary | yland, 20852 |
| Baltimore, | Pages 1 and next of He and: If item | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) | | | position (Name of ematory or other place) National | 11-28- | -2005 | c. Location - City or To 1 ington, N | |
| Balt | permit. Departrimporta | | 21. Signature of Fune of Service Lice s | och- The | rely P | 22. Name and Address of ike, Rockvi | Facility Simp 11e, MD | lesTribu 20852 | te, 1040 I | Rockville |
| * | Physician /Medical Examiner | | 23a. Part1. Enter the disease, of comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) | a | ed the seath. Do not en line. | oc A | ich as cardiac or | respiratory arrest | ction | Approximate Interval Between Onset and Death |
| 8760, | icate be executed physician and si the burial-transit | Icai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. <i>De</i> | is a consequence of): | - Fle | nre UK | 7 100 | (18t | Yesn |
| P.O. Box 68 | The law requires that the death certifics ate has been signed by the attending propage 2 should be detached for use as it. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | | 2 Fetal death 3 | □Ectopic pregnancy □ Other (specify) | | | 23d. Date of delive | • |
| | quires that n signed b uld be deta | ۵ | Part II, Dther significant conditions co | ntributing to death | but not resulting in the | underlying cause given in | Part I. | | co use contribute to t | 1/ |
| of Vital Records, | : The law requir cate has been si page 2 should i | Completed | | | | | | 24a. Was an autopsy performed | prior to co death? | opsy findings available impletion of cause of |
| <u> </u> | /sician s certif director | To Be | 25. Was case referred to medicat examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpat | tient 2 ER/Outpatio | Othor | | (Check only one) e 5 □ Besidenc | e 6 ☐Other (Specia | 5/) |
| | Attending Physician: r death. sctor: After this certifica | | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of In (Month, D | jury 28b. Time | | 20 | 3d. Describe how | | 77 |
| Division | al or Atter after dea I Director d in by the | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | | njury - At home, farm, s etc. (Specify) | treet, factory, office | 2 | 8f. Locetion (Stree City or Town, S | at and Number or Rura State) | al Route Number, |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | edical C | 29a. Certifier 1 Certifying Phy (Check only one) Medical Exami | rsician: To the besiner: On the basis and manner s | of examination and/or | ath occurred at the time, d nvestigation, in my opinion | ate and place, ar n, death occurre | nd due to the caus d at the time, date | e(s) and manner as s and place, and due t | tated. o the cause(s) |
| | To the To To To To To To To To To To To To To | ¥. | 29b. Signature and title of certifier | K |) // M | 29c. License nur | mber 2 2 (| 29d. | Date signed (Month, | Day, Year) |
| • | | | 10 // relen | s July | July 1 | J 113 | > 16/ | 0'0 | Token 3 | 1 200 5 |
| _ | 12 | | 30. Name and address of person who co Chevy Chase, MD 2 | 0815 | r death (Item 23a) (Type | William William | R. Doole | ey, MD, 3 | 31 West Ki | rke St., |
| | Sta Registi | | 31. Date filed (Month Pay, Year) 9 | 005 32. Aégis | strar's Signature | parte | | | | |

| | | | 1 - For State Registrar | State of Man | | artment <i>rtificate</i> | | | Mental Hy | giene | | 38408 |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------|----------------|---------------------------------------|---------------------------------------|----------------------------------|-----------------------------|----------------------------------------------------------------------------|
| I | Physici /Medio | | 1. Decedent's Name (First, Middle, Last) Marie Lee Loo | | | | | | 2. Date of De Month | Da 2005 | | 7:50 a M |
| | Examir | er | 4a. Facility Name (If not institution, give s Casey House | | | Rockv | | | | N_{i}^{r} | County of Dea | ry |
| | Funeral Director | | 5. Social Security Number 6. Sex 272–32–6303 Usual Residence of Decedent | 7. Age (1) 7. Age (1) 7. Age (1) | In yrs. last birthday) Yrs. | If Under 1 Months | Days Ho | nder 24 Hrs urs Min | | rth ay, Ye <i>ar)</i> 1929 | 9. Bi | thplace (State or Foreign ountry) na |
| | within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show he Madical Examiner must be notified at | ector | 10a. State 10b. County Maryland Montgomer 10e. Street and Number | | Oc. City, Town or Lo | 10f. Zip 0 | Codo | | | 10a Ci | tizen of What C | 10d. Inside City Limits 1 ☐ Yes 3 ☐ No |
| | s 23a or | Funeral Director | 7004 Richard Drive | | | 2081 | 7 | | | Jnite | ed Stat | es |
| 900 | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be multired at | þ | 11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | Was Decede If Yes, specif | fy Cuban, Me | c Origin? (s xican, Puer ecify: | Specify Yes or No rto Rican, etc.) | 0- | 14. Race - Am Black, Whi | te, etc. |
| Maryland 21215-0036 | filed within 72 h Hygiene. other then "natu | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | | (Give | dent's Usual kind of work DO NOT use | done durina | most of wo | orking | | ind of Business | /Industry |
| yland 2 | should be filed and Mental Hygin marked other umatic event, II | To Be C | 17. Father's Name (First, Middle, Last) Kan Lee | | Hone | nakei | i | | me (First, Middle en Whang | , Maiden | | |
| di. | is 1 and 2 sho of Health and Item 27 Ie my other traum | | 19a. Informant's Name/Relationship (Tyr Ti Li Loo/Spouse 20a. Method of Disposition | | | Richa | rd Dri | | ethesda, | MD | | |
| Baltimore, | permit. Pages 1 Department of H Important: If Ite any Injury or ot once. | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of of Funer I Service | emoval from State | Brentwood | matory or oth | yland | i | 7, 2005 | Bre | ntwood | |
| Ä | Der Imp | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | cations that caused he | Pi | ike, Ro | ockvil | le, M | D 20852 | | ., 1040 | Approximate |
| | Physician /Medical Examiner | | shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | | ic Cancer | | | | | | | Interval Between Onset and Death |
| 8760, | ate be executed hysicien and the burial-transit | cal Examiner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a c | | | | | | | | |
| O. Box 6 | law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit | Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 3c. If yes, outcome of p 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown | Fetal death 3 | ⊒Ectopic preç ∃ Other (spec | | | | | 23d. Date of de Month | livery Day Year |
| rds, P. | w requires that been signed t should be deta | þ | Part II. Other significant conditions con | ntributing to death but n | not resulting in the u | inderlying cau | use given in F | art I. | | obacco u Yes 2 | | o the cause of death? robably 4 🗀 Unknown |
| al Records, | The ate h page | Completed | | | | | | | 24a. Was auto perfo 1 ☐ Yes | | prior to death? | utopsy findings available completion of cause of s 2 \(\text{No} \) |
| ion of Vital | Attending Physician: r death. sctor: After this certific by the funeral director, | ation: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manger of Death 1 Natural 5 Pending 2 Accident investigation | lospital: 1 Inpatient 28a. Date of Injury (Month, Day Yo | 2 ER/Outpatier 28b. Time o Injury | | 1 | Nursing I | ath Check on o | dence | | _{lcify)} Hospice |
| Division | tal or Attencers after death all Director: | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. (S | - At home, farm, str Specify) | reet, factory, | office | | 28f. Location (City or To | Street an wn, State | d Number or R | ural Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Director Completely filled in b | Medicai | (Check only Z Medical Examinate one) | sician: To the best of n ner: On the basis of ex and manner stated | amination and/or in | vestigation, in | n my opinion, | death occ | urred at the time, | date and | place, and due | e to the cause(s) |
| ļ | | - | 29b. Signature and title of cardiller | Me | h (line 20.) = | - [| License num | 248 | | 11. | e signed (Mont | 2005 |
| 200 | 30 | | 30. Name and address of person who co Road, Rockville, M 31. Date filed (Month, Day, Year) | | | Print) Cha | arles l | darri | son, M.D | ., 6 | 001 Mun | caster Mill |
| | Sta Registr | | NOV 0 9 2 | 005 Jaguar | J B B | barke | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 10, 2005 Robert Lee Lacy 3:30 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Garrett County Memorial Hospital Oakland Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth June 23, 1932 **Funeral** 9. Birthplace (State or Foreign Days Hours 1 M 2 □ F 314-30-6382 73 Yrs. Indiana Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Set 27 is marked other then "neturel", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23e or 28e-f show Director 1 ☐ Yes 2 No MD Garrett McHenry 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 529 Wagner Road 21541 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. The Madical Examiner : 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs Industrial Engineer U.S. Steel of Health and Mental Hygis: If item 27 is marked other or other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Lacy Hazel Bell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite W. Lacy/wife 529 Wagner Rd., McHenry, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any njury or once. Nov 13, 2005 Davidsville, PA * 4 ☐ Donation 5 ☐ Other (Specify) Country Side Crem. 21. Signature of Funeral Service Newman Funeral Homes, P.A., PO Box 275 lumae 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician disease or condition resulting in death) CHF yrs. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ASHD yrs. Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Urethral cancer, metastatic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 ☐ Yes 2 No Other: Certification: To ↑ Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death.

Inerel Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 11/10/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Paolini, M.D., 317 Pythian Ave., Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 14 2005

| | | | State of Maryland / De | epartment of Health and Certificate of Death | • | enns 38410 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------|
| 3 | Physic | | Decedent's Name (First, Middle, Last) MARGARET JOSEPHINE LONG | | 2. Date of Death Month D | 3. Time of Death |
| | /Medi Examir | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Deat | h 4 | c. County of Death |
| A.C. | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho | Months Days Hours Min | 8. Date of Birth (Month, Day, Year | 9. Birthplace (State or Foreign Country) |
| di. | Birector ■ | | 213-44-2009 61 Yrs Usual Residence of Decedent | s. Mariano Bays 110013 Million | | 944 MARYLAND |
| | Marylan f ehow | ō | 10a. State 10b. County 10c. City, Town of MD ALLEGANY CUMBE | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | or 28a- | Funeral Director | 10e. Street and Number | 10f. Zip Code | 10g. C | itizen of What Country? |
| | me 23e | erai | | 3 21502 13. Was Decedent of Hispanic Origin? (S | | U.S.A. 14. Race - American Indian, |
| 36 | be filed within 72 hours after death with the Maryland hat Hygiene. Id other then "naturel", or lieme 23a or 28a-f ehow event, the Medical Eventinar must be rodified at | by Fur | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl ¹ ☐ Yes 2 M No Specify: | o Rican, etc.) | Black, White, etc. |
| 21215-0036 | 72 hour | eted b | 15. Decedent's Education 16a. De | acedent's Usual Occupation live kind of work done during most of wor | 16b. I | WHITE Kind of Business/Industry |
| 2121 | within liene. | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | e. DO NOT use retired) IETARY WORKER | | HOSPITAL |
| | be filed htal Hygie od other | Be | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, Maide | |
| Maryland | should be ind Menta i marked umatic ev | 2 | (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. M | MARY V ailing Address (Street and Number or Ru | | or Town, State, Zip Code) |
| | l and 2 lealth a im 27 li | | DAVID MAWHINNEY / COUSIN 121 | .41 MARIGOLD AVENUE | , CUMBERLAN | D, MD 21502 |
| Mor | Pages lent of the nt: If its ry or of | | iXXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, of | sposition (Name of crematory or other place) MEMORIAL PARK 11/15 | | ocation - City or Town, State |
| Baltimore, | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny Injury or other treumatic es <u>DDGS</u> . | | 21. Signature of Funeral Sovice Livense e | 22. Name and Address of Facility UPCHURCH FUNERAL 202 GREENE STREET | HOME, P.A. | CUMBERLAND, MD |
| | Physician | | 23a. Part 1. Enter the disease, or combications that caused the death. Do not shock, or heart failure. List only one cause on each line. | enter the mode of dying, such as cardiac | or respiratory arrest, | ND, MD 21502 Approximate Interval Between Onset and Death |
| E. | /Medical Examiner | | disease or condition resulting in death) a | vascular VIC | COCOUL | |
| | 10000000000000000000000000000000000000 | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | 15/24 | | |
| | te be executed ysician and te burial-transit | Examiner | Cause (Disease or injury that initiated events c | | | |
| 8760, | \$ × × | cal | d | | | |
| Вох 6 | E 00 40 | n/Mec | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | 23d. Date of delivery |
| o. | w requires that the death cer been signed by the attendir should be detached for use | Physician/Med | in the past 12 months? | 3 Ectopic pregnancy 5 Other (specify) | | Month Day Year |
| α. | Attending Physician: The law requires that the rideath. actorize Affer this certificate has been signed by the year the funeral director, page 2 should be detached the funeral director. | þ | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | | use contribute to the cause of death? |
| Records, | s been s | Completed | Universe Track in her han | | 1∐ Yes 2 24a. Was an | No 3 Probably 4 → Unknown 24b. Were autopsy findings available |
| | hysician: The lav | Com | Congestine Hears Fo | illuse | autopsy performed? | prior to completion of cause of death? |
| Vits Vits | ysician s certifi director | To Be | 25. Was case referre to medical examiner? 1 Yes 2 Ne Hospital: 1 1 Inpatient 2 ER/Outpat | 000 | th Check onl, one | G DOWN (C. a.t.) |
| Division of Vital | ding Phy th. After thi funeral | | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injur | e of 28c. Injury at Work? | 28d. Describe how injur | |
| Visio | | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | M 1 ☐ Yes 2 ☐ No street, factory, office | 28f. Location (Street ar | nd Number or Rural Route Number, |
| ٥ | 0 # 5 5 | Cert | addang, add. (opcony) | | City or Town, State | , |
| | To the Hospital within 24 hours a To the Funeral I completely filled | edicai | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated. | sath occurred at the time, date and place, investigation, in my opinion, death occur | and due to the cause(s) red at the time, date and | and manner as stated. I place, and due to the cause(s) |
|) | To the vithin 2 Complete | Σ | 29b. Signature and title of certifier | 29c. License number | | te signed (Month, Day, Year) |
| | | | 30. Name and address of p rson who completed cause at h (Item 23a) lyp | pe, Print) | | 11/11/01- 1 MD 7 1507 |
| 2 | TIR) Sta | te | 31. Date filed (Month, Day, Year) 32. Projectra's Signature | 3010 D- (a) | mberlai | I MO C (SOT |
| 13 | Registr | ar | NOV 1 5 2005 Alexand St. | Coerte | | |

| | | | 1 - State Registrar | State of N | Maryland / Depa Ce | artment of H | ealth and Death | | iene g. No. | 38411 |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|-----------------------------------------------|--------------------------------------|-----------------------|-----------------------------------------------|-----------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | th Nav Year | 3. Time of Death |
| | Physici: /Medic | | Richard R. Leonard | d | | | | Novembe | r 8, 2005 | 11:35рм |
| | Examin | | 4a. Fecility Name (If not institution, give s Frostburg Village | | | 4b. City, Town, or Frostbu | | ath | 4c. County of De | |
| | Funeral Director | | 5. Social Security Number 6. Security 160 - 12 - 1845 | | Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hi Hours Mi | | Year) (| rthplace (State or Foreign country) |
| | pur 🔭 | - | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | f sho | ō | , | | | | | | | 1 X Yes 2 □ No |
| | the A | rect | MD Allegany 10e. Street and Number | | Frostbu | 10f. Zip Code | | 1 | 0g. Citizen of What 0 | Country? |
| | 3a or | Funeral Director | One Kaylor Circle | | | 21532 | | | USA | • |
| | death | nera | | 12. Was Deceder Armed Force | | Was Decedent of H | spanic Origin? | (Specify Yes or No- | 14. Race - Am | |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at | þ | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ If Yes, Give Year or Date: | No | If Yes, specify Cuba 1 ☐ Yes 2 Ø No | Specify: | erto Alcan, etc.) | Specifill hi | |
| Ö | 72 hol | Completed | 15. Decedent's Edu (Specify only highest grade | cation | 16a. Dece | dent's Usual Occupa | ation | nrkina | 16b. Kind of Busines | s/Industry |
| 21 | ithin 7 | nple | Elementary/Secondary (0-12) | College (1-4c | ir 5+) | DO NOT use retired |) | | | |
| 21 | led will ygien ygien her th | | | 4 | Ele | ctrical E | | ame (First, Middle, i | Electric | al |
| and | be fill Hall Hed otl | Be | 17. Father's Name (First, Middle, Last) Daniel Leonard | | | | | ca Albria | | |
| Maryland | S should be filed withliand Mental Hygiene. Is marked other than aumatic event, the M | ဥ | 19a. Informant's Name/Relationship (Tv | ne Print) | 19b Maili | ng Address (Street a | | | City or Town, State, | Zin Code) |
| Ma | ith an | | | Son. | | Vernacolin | | | 1. MD 2150 | |
| ē, | Heart tam | | 20a. Method of Disposition | 3011 | 20b. Place of Dispo | sition (Name of | al I | Date | 20c. Location - City of | r Town, State |
| E G | Page ento nt: ff ry or | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify) | lemoval from Sta | IA | | 1 | 10 0000 | Hundman, | PA |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any injury or other tra | | 21. Signature of Fundral Service License | 9 | Hyndman | 2. Name and A res | s of Facility | -12-2005 | 7.137,200 | |
| œ | 9 5 E 8 9 | | I Leigh | w | | Harvey H. | Zeigle | r Funeral | Home, Hyr | idman, PA |
| П | | | 23a. Part1. Enter the disease, of complishock, or heart failure. List only or | ne cause on each | line. | | | | | Approximate Interval Between |
| Щ | Physician | 63 II | Immediate Cause (Final disease or condition | 1 | Strok. as a consequence of): | e with | Right | Hemiple 9 | ia | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or | as a consequence of): | r c. | 0 | 1 0 | | 20 years |
| | | _ | Sequentially list conditions, | Daw to 450 | as a sonsuguenes sh: | orden She | h | | | = c fears |
| | ted nsit | nin | lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 50010 (0. | 20 2 0011004201100 31/1. | | | | | |
| <u> </u> | execunand and ial-tra | Examiner | resulting in death) Last | Due to (or a | as a consequence of): | | | | | |
| 8760, | cate be executed physician and s the burial-transit | dical | | d | | | | | | |
| 9 | tifical ng phy as th | Aedi | IC CC LAI C | | | | | | | |
| Вох | eath certific attending p | an/h | 23b. was decedent pregnant | 3c. If yes, outcor 1 ☐ Live birth | | ∃Ectopic pregnancy | | | 23d. Date of d | elivery Day Year |
| o. | The law requires that the death certifi ate has been signed by the attending I bage 2 should be detached for use as | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant 9□Unknown | | Other (specify) | | | Monu | Day 18ai |
| D, C | res that igned b | by P | Part II. Other significant conditions con | 4 | but not resulting in the u | nderlying cause give | en in Part I. | 23e. Did tol | pacco use contribute | to the cause of death? |
| Records, | w require been sig | led | Ad Vonce | al a | ge | | | 1 □ Ye | es 2 No 3 F | robably 4 Munknown |
| 900 | e law re has be je 2 sh | ple | | | | | | 24a. Was a autops | y prior to | utopsy findings available completion of cause of |
| 33 | | Completed | | | | | | perfore | ned?// death? | s 2 No |
| Vital | Physician: The this certificate rat director, pag | Be | 25. Was case referred to medical examiner? | Agenital: | | Othe | | eath (Check only on | Θ) | |
| of | di is | . To | 1 Yes 2 No | lospital: 1 Inpa | niury 28b Time o | II 3 DOA | 4 Nursing | | ence 6 Other (Sp ow injury occurred | ecify) |
| on | ding Ph th. After th funeral | tlon | 1 VNatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, i | Day Year) Injury | Worl | k? Yes 2 □ No | | ,, | |
| Division | Attanding or death. | lfica | 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of | Injury - At home, farm, st | reet, factory, office | | | reet and Number or F | Rural Route Number, |
| D | s afte | Certification; | 4 Homicide | building, | etc. (Specify) | | | City or Town | n, State) | |
| | To the Hospital or Attanowibin 24 hours after death To the Funaral Director, completely filled in by the | Medical (| 29a. Certifier 1 Certifying Physical Check only one) | sician: To the be ner: On the basis and manner | st of my knowledge, deat of examination and/or in | h occurred at the tim vestigation, in my o | ne, date and pla pinion, death oc | ce, and due to the co | ause(s) and manner a ate and place, and du | is stated. le to the cause(s) |
| - | ro the vithin of the omple | Mec | 29b. Signature and title of certifier | 1 | 11 | 29c. License | number / | 2 | 9d. Date signed (Mor | |
| | 15 | | > 2 | (Jan | -dhir Hi | D | 1446 | 4 | 11-10- | 2005 |
| | | | 30. Name and address of person who co | | | | | | | |
| | nus | | S.L. SANDHIR | | rn Ter. So | site 201 | Frostb | ory MD | 21532 | |
| | Sta | | 31. Date filed (Month, Day, Year) | | strar's Signature | 1.1. | | 1. | | |
| | Regist | al | NOV 1 4 200 | h / 180 | C-12 1 13 13 | 23481J | | | | |

| | | | 1 - For State Registrar | State of Ma | aryland / Depa <i>Ce</i> | artment of H rtificate of L | | - | giene Reg. No. () (| 05 | 384 | 12 |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------|------------------------------------|-------------------------------------------|------------------------------------|------------------------------------------------|----------------------------------------|----------------------|
| ı | Physici | an | Decedent's Name (First, Middle, Last) | | | | | 2. Date of De Month | eath Day | Year | 3. Time o | of Death |
| | /Medic Examir | | LORETTA C. MAROI 4a. Facility Name (If not institution, give s. | | | 4b. City, Town, or | Location of De | NOVEMBER eath | 4c. Count | v of Death | 5:05 | _ A |
| ı | Lxumii | | HOLY CROSS HOSPITAL | | | SILVER SPR | | | MONTGO | | | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age M 2反F | (In yrs. last birthday) | If Under 1 Year Months Days | If Under 24 h | Hrs. 8. Date of Bir (Month, Da | th | | place (State | or Foreign |
| | Director | | Usual Residence of Decedent | - X | 77 Yrs. | | | JUNE 17, | 1928 | ILLING | | |
| | yland | | 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | - | 1 | 10d. Inside C | City Limits |
| | n the Maryland r 28a-f ehow | ctor | MARYLAND MONTGOMERY | | SILVER SPRIM | NG | | | | | 1 🗌 Yes | s 2X No |
| | vith th | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | What Cour | ntry? | |
| | eath v | Funeral | 1016 DEVERE DRIVE | 2. Was Decedent B | Ever in H.S. 13 | 20903 | spania Origin? | (Specify Yes or No | U.S.A. | 20 Amori | can Indian, | |
| 330 | d within 72 hours after death with the Maryland Jene. r than "natural", or Items 23a or 28a-1 ehow the Musical Examinat must be notified at | by Fun | 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced | Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates: | 10 | IT Yes, specify Cuba | Specify: | uerto Rican, etc.) | Bla | ck, White, | etc. | |
| 5-0036 | 72 hou | | 15. Decedent's Educ (Specify only highest grade | cation | | dent's Usual Occupa | | wating | 16b. Kind of B | | | |
| Z | within 72 ene. than "na | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | +) life. | DO NOT use retired |) | working | | | | |
| 7 0 | illed v Hygie other t | | 12 17. Father's Name (First, Middle, Last) | | HOMEMAR | ŒR | 18 Mother's N | Name (First, Middle, | OWN HON | | | |
| | d is b | To Be | | 'KEEFE | | | BRIDGET | | , Maidell Sullat | ile) | | |
| ary | should and Men s marke umatic | ۲ | 19a. Informant's Name/Relationship (Typ | | 19b. Mailir | ng Address (Street a | | ROCHE Rural Route Number | er, City or Town | , State, Zip | Code) | |
| Σ. | and 2 salth a n 27 is | | JOSEPH G. MARON, SR./HUS | SBAND | 1016 DE | VERE DRIVE, | SILVER | SPRING, MAR | YLAND 209 | 03 | | |
| ore | Titer H | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re | emoval from State | 20b. Place of Dispo cemetery, crer | sition (Name of matory or other place | 9) | Date | 20c. Location | - City or To | own, State | |
| altimor | rtant: | | 4 □ Donation 5 □ Other (Specify) | | FORT LINCOL | | | 15/2005 | BRENTWOOD | , MARY | LAND | |
| n n | permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke eny injury of other traumatic once. | | 21. Signature of Funeral Service License | udeuro |) 11 | . Name and Addres .800 NEW HAM | IPSHIRE A | INES-RINALD VENUE, SILV | I FUNERAL ER SPRING | HOME, MARY | INC. TAND 20 |)904 |
| | Pnysician /Medical Examiner | Examiner | 23a. Part 1. Enter the disease for complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | DEMENTIA Due to (or as a | a consequence of): a consequence of): | er the mode of dying | j, such as card | diac or respiratory au | rrest, | | Approxima Interval Bet Onset and | tween |
| . Box og/ou, | The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit | Physician/Medical Ex | JE FEMALE: | 3c. If yes, outcome of 1□Live birth | 2 ☐ Fetal death 3 ☐ | Ectopic pregnancy | | | | te of delive | , | Year |
| r 5 | d by the | Phys | 9 Unknown | 9□ Unknown | | | | | | | | |
| cords, | w requires the been signed should be contact. | ted by | Part II. Other significant conditions cont CEREBRAL VASCULAR ACCIDE | | | nderlying cause give | n in Part I. | | obacco use con | | | |
| a nec | | Completed | SEIZURE DISORDER , DEPRE | SSION | | | | 24a. Was autop perfo 1 🗆 Yes | rmed? | Were auto prior to cor death? 1 □ Yes | psy findings mpletion of c 2□ No | available ause of |
| | sicien | o Be | 25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☒ No | ospital: | | t 3 DOA Othe | ~ | Death Check only o | | | | |
| 5 | > .w 0 | \vdash | 27. Manner of Death | 28a. Date of Injur (Month, Day | | 1 3L DOA | 4 🗆 Nursing | g Home 5 ☐ Resid | | | 0 | |
| 5 | ath. rr: Aft | atio | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | Year) Injury | | ? ′es 2 □ No | | | | | |
| DIVISION | tel or Atters after de el Directo | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Inju- building, etc | ry - At home, farm, str . (Specify) | eet, factory, office | | 28f. Location (S City or Tow | Street and Numb vn, State) | er or Rura | I Route Num | nber, |
| | To the Hospitel or Attending Physicien: within 24 hours aller dealn a 'To the Funerel Director: After this certific completely filled in by the funeral director. | Medical | 29a. Certifier (Check only one) 1 ☐ Certifying Physical Control one) 2 ☐ Medical Examina | ician: To the best of er: On the basis of and manner sta | f my knowledge, death examination and/or inv ted. | occurred at the tim restigation, in my op | e, date and pla inion, death oc | ace, and due to the occurred at the time, | cause(s) and ma date and place, | anner as st and due to | ated. the cause(s | s) |
| | To To To E | Σ | 29b. Signature and title of certifier | 12 | | 29c. License | number | | 29d. Date signe | d (Month, i | Day, Year) | |
| | W | | Mahatt Le | iac) N | (r) | MD D00 | 55522 | | NOVEMBE | 8 8, 20 | 005 | |
| | | | 30. Name and address of person who com ROBERT H. GERARD, M.D., | | | • | TO MADE | AND GOOD | | | | |
| | Sta | | 31. Date filed (Month, Day, Year) | | r's Signature | SILVER SPKI | vo, MAKYI | 709TO | | | | |
| | Registr | ar | MOA T 0 500, | 3 Person | 1 SO PORTO | | | | | | | |

| | | - | For State Registrar | State of Maryland | | rtment of l tificate of | | | giene Reg. No. |)5 | 38413 |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------|-------------------------------------------------------|-----------------------------------------|--------------------------------|-------------------------|----------------------------------------------------|
| 33 | Physicia | 20 | Decedent's Name (First, Middle, Last) | | | | | 2. Date of De Month | Day | Year | 3. Time of Death |
| | /Medic | al - | Macel Helen McGil 4a. Facility Name (If not institution, give st | | | 4b. City. Town. | or Location of Deat | | er 7, 2 | 2005 ty of Death | 8:49 a M |
| | Examin | er | Holy Cross Hospit | | | | Spring | | | ntgon | |
| | Funeral | | Social Security Number 6. Sex | 7. Age (In yrs. la | | If Under 1 Year Months Days | If Under 24 Hrs | | th | 9. Birth | place (State or Foreign intry) |
| 4 | Director | | 332-05-9303 | M 203 F 93 | Yrs. | | | | 16, 191 | 2 111 | inois |
| | land bw | - | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | | 10d. Inside City Limits |
| | Mary | tor | Maryland Montgomer | ry Ke | ensing | ton | | | | | 1 ☐ Yes 2 🖾 No |
| | or 28s | Directo | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | | untry? |
| | death with the Maryland ms 23a or 28a-f ehow | | 10710 Casper Stree | | | 20895 | Historia Osigia? (S | anafu Van or No | | JSA | ican Indian, |
| | y within 72 hours after death with the Marylan jiene. Than "naturel!, or tiems 23a or 28a-1 ehow The Madical Examiner must be politied at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: | 1 | was Decement or f Yes, specify Cul 1 ☐ Yes 2☐KNo | Hispanic Origin? (S ban, Mexican, Puer Specify: | to Rican, etc.) | Bt | ack, White | , etc. |
| 21215-003b | 2 hou | | 15. Decedent's Educ | | 16a. Deced | ient's Usual Occu | pation during most of wo | rkina | 16b. Kind of | Business/Ir | ndustry |
| 712 | ithin 7 | Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life. I | DO NOT use retir | ed) | 9 | | ed Sta | ates |
| | 2 00 00 - | Co | 12 17. Father's Name (First, Middle, Last) | and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t | Exe | cutive S | ecretary | me (First, Middle | Senat | | |
| Maryland | d be filed ental Hyg ced other c event, | To Be | Guy C. Shaw | | | | | e Belle | | , | |
| ar Z | shoul and Mari mari | F | 19a. Informant's Name/Relationship (Typ | e, Print) | 19b. Mailir | ng Address (Stree | t and Number or R | ural Route Numb | er, City or Tow | n, State, Zi | ip Code) |
| Σ | and 2 eaith a n 27 I | | Ann L. Griffin/ Da | <u> </u> | | | y Lane, I | | | | |
| nore | t: If ite | | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) | emoval from State | emetery, crer | sition (Name of matory or other pl National C | | mber 14 2005 | 20c. Location | - | /irginia |
| Baltimore, | permit. Pages 1 and 2 should be file Deperminent of Healin and Mental Hy Important: If item 27 is marked oth ery Injury or other traumatic event once. | | 21. Signature of Funeral Service License | е | | | ess of Facility Collins rsity Bly | | | | g, MD 20901 |
| - 3 | ÷. | | 23a. Cart1. Enter the disease, or complice shock, or heart failure. List only on | cations that caused the death | n. Do not ent | er the mode of dy | ring, such as cardia | c or respiratory a | arrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Diverticuli | tis | | | | | | Onset and Death |
| apt Sans | /Medical Examiner | . | resulting in death) | Due to (or as a consequ | uence of): | | | | | | |
| i | | 100 | Sequentially list conditions. | Dehydration Due to lor as a consequence | uence of): | | | | | | |
| | uted | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Atrial Fibr | illati | on | | | | | |
| oʻ | exect an and rial-tra | | that initiated events c resulting in death) Last | Due to (or as a consequ | | | | | | | |
| 8760 | icate be executed physician and s the burial-transit | dicai | | Ischemic Boy | vel | | | | | | |
| Box 6 | eath certific attending p | J/Me | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregna | | | | | 23d. D | Date of deliv | very |
| P.O. B | the death y the atte | Physician/Me | in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown | 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown | | Ectopic pregnan Other (specify) | | | N | Month | Day Year |
| ds, P | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | þ | Part II. Other significant conditions con Chronic Lymphocyt | • | - | | liven in Part I. | | | | the cause of death? obably 4 [Munknown |
| <u>0</u> | aw requir s been si 2 should [| Completed | | | | | | 24a. Was | s an 24b | . Were au | topsy findings available completion of cause of |
| <u> </u> | The lavete has | Com | | | | | | perf | ormed? 2. XNo | death? | 2 🗆 No |
| ita | ician: Th certificete rector, pag | Be | 25. Was case referred to medical examiner? | | | | thon | ath (Check only | | | |
| Division of Vital Records, | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page | lon: To | 27. Manner of Death 1 XNatural 5 Pending | ospital: 1 🔀 Inpatient 2 🗆 28a. Date of Injury (Month, Day Year) | ER/Outpatie 28b. Time o Injury | f 28c. In | | Home 5 Res 28d. Describe | how injury occ | | cify) |
| ivisio | or Attend after death Director: | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Specification) | | | | 28f. Location City or To | (Street and Nur own, State) | n <i>ber or Ru</i> | ral Route Number, |
| | To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by | edical Ce | (Check only 2 Medical Examin | sician: To the best of my kno ner: On the basis of examina | wledge, deat | h occurred at the | time, date and place | e, and due to the curred at the time | e cause(s) and i | manner as e, and due | stated. to the cause(s) |
| | thin 2 thin 2 the 1 implet | Med | 29b. Signature and title of certifier | and manner stated. | | 29c. Lice | nse number | | 29d. Date sign | ned (Monti | h, Day, Year) |
| | 3D | | ful | Saudh | u | De | 3334 | | Novemb | er 7, | 2005 |
| | 70 | | 30. Name and address of person who con Haval M. Saadla, | impleted cause of death (Item | 23a) (Type | | d, Silve | r Sprina | , MD 20 | 910 | |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) | 32 Registrar's Signa | iture / | and I | | | | | |

Mark P. Miedzinski Amend item#4a-b perME, C849, 11/29/05 TT
State of Maryland Department of Health and Mental Hygiege 05 05 - 7496**AKG** For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician Mark Paul Miedzinski November 6, 2005 4:20 P /Medical 4a. Facility Name (If not institution, give street and number)

1 Doctors Community Hespital 4b. City, Town, or Location of Death Examiner Laurel Prince George's Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Now (Month) Day (1994) 6. Sex M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Maryland 218-66-9598 48 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Iown or Location New Carrollton Maryland Prince George's 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-1 show important: if item 27 is marked other than "natural", or itams 23a or 28a-1 show in july or other traumatic event, the Madical Exercities must be notified at once. 1 Yes 2 No Director 10g. Citizen of What Country? United States 10e. Street and Number 6016 Mentana Street 20784 Funeral 12. Was Decedent Ever in U.S.

Afmed Forces?

↑ □ Yes 2 □ No

If Yes, Give
Year or Dates In known Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

YOOFER 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry construction Elementary/Secondary (0)12) College (1-4or 5+) 17, Father's Name (First, Middle, Last) Martin Paul Miedzinski 18. Mother's Name (First, Middle, Maiden Sumame) NOTMA Greenfield Be 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 14849 Silver Ash Court Burtonsville, Maryland 20866 19a. Informant's Name/Relationship (Type, Print) Michael Miedzinski -brother 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 11/9/2005 20c. Location - City or Town, State Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Europa Skrvice Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) apper Gastromtistinal Hemory hage **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours efter death.
Funeral Director: After this certificate has been signed by the attending physicien and attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiovasculas Disease Chronic 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should t 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 1X Yes 2□ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and Hitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 7, 2005 OCME uma

Registrar

31. Date filed (Month, Day, Year)

NOV 1 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene, For Stata Registrar Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 12, 2005 **Physician** Minard Cecil 2:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Bethesda Health & Rehab Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 23, 1922 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F 216 18 1304 Director WVa Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Medical Expressor, ust be inclined at MD Garrett 0akland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1954 Spring Glade Rd. 21550 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (\$\frac{1}{2}\text{Yes} 2 □ No If Yes, Give WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Building 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Minard Olga Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an ent; if item 27 is: David A. Burdock 21 N 2nd St. Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Importent: If eny injury or once. Deer Park Cemetery 11-16-05 Deer Park, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burdock-Durst FH 21. Signature of Funeral Service Licensee 21 N 2nd St. Oakland, MD 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4☐Pregnant at time of death ed by the a detached f 9☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Peripherial Vascular Disease 1 Yes 2 No 3 Probably 4 2 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 1 Yes 2 🕱 No Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospitei or Attending Injury 1 X Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fun completely i 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0053615 Nov 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Rockville Pike #208 Rockville, MD 20852 A. Nathan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:55 P^M Clara Davis November 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6920 Green Valley Road <u>Frederick</u> 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 060-16-0644 86 Yrs Director Maine Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Frederick New Market 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6920 Green Valley Road 21774 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: Specify: ş 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Vice President / Treasurer Aviation Insurance event, # 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event p.cs. 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Leslie Davis Martha Riggs Fisher Crosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph D. Maher, Jr. / Husband P.O. Box 2 New Market, Maryland 21774 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State November 14,2005 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 21. Sign vure of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused in the property of heart failure. Lest only one cause on each line r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician malianant neopleam non465 /Medical Due to (or as a consequence of). Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last monn Examiner physicien and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? õ Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Kunknown hes been sign 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29b. Signature and bits of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO43389 eleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 198 Thomas Johnson Dr #200 Frederick MD21703 BEXAKIEM ME .. Registrar's Signature State Registrar

Amend # 1 PentHY. 11-10-05 A.A. (b. Health Dept. PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Amend Item#5 per INF Waryland Pepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Thomas K. Malone, Jr. 2. Date of Death Month **Physician** 10:20 NOVEMBER 8, 2005 /Medical City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Johns HOPKINS HOSPITAL . Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 86 Director 10-23-1919 Vermont Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State item 27 is marked other than "netural", or items 23e or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Talbot Oueen Anne Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30093 Pahlman's Way 21657 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "netural", or itei 1 X Yes 2 No If Yes, Give Year or Dates: 1943–46 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Banking Banker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Marie Trombley Thomas Keeshan Malone, Jr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30093 Pahlman's Way, Queen Anne, MD 21657 Dorothy M. Malone/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. injury or Columbia Gardens Cem. 11-12-05 Arlington, VA 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastati cancel Physician Mulanorus /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; I Director: Atte 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a
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completely filled 29a, Certifier 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59240 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St., Jefferson 242, Raltinione, MD 212897 ena Chen, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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| Funeral Director | | 4a. Facility Name (If not institution, gi STMANS VILLE 5. Social Security Number 6. | Bing Center - Sex 7. Age (In yrs. G.C. | | Leonal If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | 8. Date of Birth | STIVI | ATY S irthplace (State or Foreign Country) |
| g | tor | Usual Residence of Decedent 10a. State 10b. County MD St. Ma | | y, Town or Lo | | 51 | | 10 | MD 10d. Inside City Limits 112 Yes 2 □ No |
| 5-0030 | eted by Funeral Director | MD St. Ma 10e. Street and Number 22680 Cedar La 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gi | ne Ct. #1124 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | .S. 13.1 | 10f. Zip Code 2 Was Decedent of H f Yes, specify Cuba I Yes 2 No Ient's Usual Occup | Specify: ation during most of wo | Specify Yes or No- to Rican, etc.) | USA 14. Race - Ar Black, WI Specify: | nerican Indian, ite, etc. 31,40K |
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| Ore, jes 1 an of Heal of Heal | | 19a. Informant's Name/Relationship Idonia Green/G 20a. Method of Disposition 1 | randdaughter 20b. P | PO B | OX 98, stion (Name of natory or other place | and Number or Ri Callawa se) | ural Route Number Y MD 2 Date | , City or Town, State | or Town, State |
| Baltim permit. Pag Department Important: any injury c | | 21. Signature of Funeral Service Line 23a. Part1. Enter the disease, or con- | nsee | 22 J P | Name and Address Box 4 | ^{ss of Facility} R 30, Dún | aymond- kirk, M | Wood F.H D 20754 | ., P.A. |
| | dical Examiner | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | one cause on each line. | uence of): | demo | - | | | Initerval Between Onset and Death |
| the death certificath the death certificath by the attending phacehold for use as the | Physiclan/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 You | 23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown | Ideath 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of d Month | elivery Day Year |
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| | e Completed | 25. Was case referred to medical | | | | | 24a. Was at autops perform | y prior to death? No 1 \(\sqrt{Ye} | autopsy findings available completion of cause of |
| ing Phys | ertification; To Be | examiner? 1 | 28a. Date of Injury (Month, Day Year) | ER/Outpatien 28b. Time of Injury | 28c. Injury Work | er: 4 Nursing H | | e) ence 6 □Other (Sp ow inju ry occurred | ecify) |
| DIVISIC Ospital or Attend hours after death Inneral Director: y filled in by the | O | 4 Homicide determined | building, etc. (Specify | y) | occurred at the tim | ne, date and place | City or Town | tuse(s) and manner a | as stated. |
| To the Hospital of within 24 hours aft To the Funeral Discompletely filled in | Medical | (Check only 2 Medical Exe | and manner stated. | tion and/or inv | 29c. License | pinion, death occu | irred at the time, da | ate and place, and du | nth, Day, Year) |
| 3 Stat | | 30. Name and address of person who A.D. Shah, M.D. 31. Date filed (Month, Day, Year) | | r Land | e Ct. Le | | own, MD | 20650 | |

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| | | | 1. Decedent's Name (First, Middle, | , Last) | | | | 2. Date of De | ath | 3. Time of Death |
| Н | Physicia /Medic | | Vera Elsie M | ulligan | | | | November November | er 5, 2005 | |
| | Examin | | 4a. Facility Name (If not institution, | give street and number | er) | 4b. City, Town, o | r Location of Dea | ath | 4c. County of De | |
| | | | Calvert County | | | Prince I | | | Calvert | |
| ľ | Funeral Director | | 548-30-6393 | 6. Sex 7. 1 ☐ M 2 X F | Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hi Hours Mir | | y, Year) | Birthplace (State or Foreign Country) nnsylvania |
| | land | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | Many -f sh | ţō | Maryland Calver | ct | Broomes I | sland | | | | 1 ☐ Yes 2 X No |
| | r 28a | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What | Country? |
| | th wit | aiD | 4031 Songbird I | Lane | | 20615 | | 1 | United Sta | tes |
| | eep . | Funeral | 11. Marital Status | 12. Was Decede Armed Force | | Was Decedent of H | lispanic Origin? (| Specify Yes or No | - 14. Race - Ar Black, W | merican Indian, |
| 36 | s afte | by Fu | 1 Never Married 2 Marrie | If Yes, Give | 1 | 1 ☐ Yes 2 ☐XNo | Specify: | | Specify: | |
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| 7. | within 72 hours after deeth with the Maryland ene. than "natural" or Items 23a or 28a-f show fra Mayleal Examiner must be notified at | Completed | (Specify only highest Elementary/Secondary (0-12) | t grade completed) | (Give | kind of work done of DO NOT use retired | durina most of w | orking | 100. Kind of Busines | samuustry |
| 212 | d with giene er tha | mo; | Elementary/Secondary (0°12) | 2 College (1-40 | | tered Nur | cse | | Health Ca | re - Hospital |
| P | be filed ital Hygi id other event, I | Be C | 17. Father's Name (First, Middle, L | .ast) | _ | | 18. Mother's Na | ame (First, Middle, | Maiden Sumame) | • |
| yla | 2 should be and Mental la marked c | 일 | Steven W. Ide | | | | | e Husted | | |
| Baltimore, Maryland 21215-0036 | iges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mental Hygiens. If filem 27 Is marked other than. If item 27 Is marked other than. or other traumatic event, Its Maches Examiner must be notified at | | 19a. Informant's Name/Relationsh Charles A. Mast | | | | | | er, City or Town, State | |
| e, | is 1 and 2. If Health ar item 27 la other trau | | 20a. Method of Disposition | ers, or. | 20b. Place of Dispo | - | ı Lane, | Date | 20c. Location - City | |
| nor | permit. Pages 1 and Department of Healt Important: If item 2 any injury or other | | 1 ☐ Burial 2 ☐ Cremation | | te cemetery, crea | matory or other plac | | | | |
| Ħ | artme ortan injur | | 4 □ Donation 5 □ Other (Sp21. Signature of Funeral Service L | | | | | | Lehman, Pe neral Home | |
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| | W. | | 23a. Part1. Enter the disease, or o shock, or heart failure. List of | complications that cause on each | sed the death. Do not en | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | * | INOMA of | EIKUR OF | Mayork | J | | Onset and Death |
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| Records, | law requires that the death certiff as been signed by the attending 2 should be detached for use a | Completed by | Part II. Other significant condition PRIJE STROKE | DERES | - | nderlying cause give | en in Part I. | 23e. Did to | | to the cause of death? Probably 4 Unknown |
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| Vital | ysician: Th is certificate director, pag | Be | 25. Was case referred to medical examiner? | | | | | ath (Check only o | ne) | |
| of | Physician: this certific ral director, | 2 | 1 Yes 2 Mo | Hospital: 1 Inpa | | Titor. | 4 Nursing | 7.7 | dence 6 Other (Sp | ecify) |
| u C | Jing J J. After funer | tion | 27. Manner of Death 1 SNatural 5 □ Pending 2 □ Accident investigs | | njury 28b. Time o Day Year) Injury | Worl | yat k? Yes 2 □ No | 28d. Describe n | now injury occurred | |
| Division | deat deat ctor: y the | fica | 3 ☐ Suicide 6 ☐ Could no | ot be | Injury - At home, farm, str | | 103 2 110 | 28f. Location (S | Street and Number or i | Rural Route Number. |
| Ö | atter s after I Dire | Certification: | 4 Homicide | building, | etc. (Specify) | | | City or Tow | n, State) | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical C | 29a. Certifier 1 Certifying (Check only one) 2 Medical E | Physician: To the be examiner: On the basis and manner | st of my knowledge, death s of examination and/or in stated. | n occurred at the time vestigation, in my op | ne, date and place pinion, death occ | ce, and due to the courred at the time, of | cause(s) and manner date and place, and di | as stated. ue to the cause(s) |
| | To th within To th | Me | 29b. Signature and title of certifier | 1 | | 29c. License | | | 29d. Date signed (Mor | nth, Day, Year) |
| | | |) (Jh H 2 | regul | | Aw | 778661 | / | Nov . 8 . | 2005 |
| | 'n | | 30. Name and address of person w | | | Print) | | | | |
| | 10 | | John H. Weigel, | MD 110 Hc | spital Road | , Suite 3 | 10, Pri | nce Frede | rick, Mary | land 20678 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 0 9 2005 × | Strages Signature | Soule | | | | |

| | | | 1 - For State Registrar | State of | Maryland / Dep <i>Ce</i> | artment of rtificate o | | and Mental F | lygien | | 38420 | |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------|--------------------|----------------------------------------------------|----------------------------------------------------|---|
| | 0 | | 1. Decedent's Name (First, Middle, Last |) | | | | 2. Date of | Death | - | 3. Time of Death | _ |
| | Physici /Medi | | Rafael Angel Math | neus | | | | Month Novemb | | ay Year 1 2005 | 3:57 A | A |
| | Examir | | 4a. Facility Name (If not institution, give | | er) | 4b. City, Town | n, or Location of | f Death | 4 | c. County of Death | 1 | |
| | | | 11812 Hayfield Co | | | Potomac Montgomery av) If Under 1 Year If Under 24 Hrs. 8 Date of Birth | | | | | | |
| | Funeral Director | | 5. Social Security Number 6. Se | x 7. ZM 2□F | Age (In yrs. last birthday, Yrs. | If Under 1 Ye Months Da | | Min. (Month, | Birth Day, Yeal | r) 9. Birth | iplace (State or Foreigi intry) | П |
| | | | Usual Residence of Decedent | | | | | Apri | 21, | 1928 Ven | ezuela | _ |
| | yland | ١. | 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | | 10d. Inside City Limits | 5 |
| | e Mar | ctor | Maryland Montgome | erv | Poto | nac | | | | | 1 ☐ Yes 2 🙀 No | ٥ |
| | or 28 | Oire | 10e. Street and Number | | | 10f. Zip Cod | Э | | 10g. C | itizen of What Cou | intry? | |
| | ath w | rai | 11812 Hayfield Co | | | | 20854 | | | USA | | |
| | filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or iteme 23e or 28e-f ehow ont, It a Madical Exactinar must be notilied at | Funeral Director | 11. Marital Status | 12. Was Decede Armed Force | nt Ever in U.S. 13. | Was Decedent of If Yes, specify C | of Hispanic Orig uban, Mexican | gin? (Specify Yes or , Puerto Rican, etc.) | No- | Race - Ameri Black, White, | | |
| 36 | rs eft | by F | 1 ☐ Never Married 200 Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 If Yes, Give Year or Date | | 1 x Yes 2□ 1 | / | _ | | Specify: | | |
| 9 | 2 hou | ed | 15. Decedent's Edu | | | dent's Usual Oc | | ezuelan | 16h | Wh: Kind of Business/Ir | ite | |
| 215 | 7, nin 7, | Completed | (Specify only highest grad Elementary/Secondary (0-12) | e completed) College (1-4) | (Give | kind of work do DO NOT use ret | ne durina most | of working | 100.1 | INITIO OF EGGINESSAN | ladatiy | |
| 21 | d with | mo | Clementary/Secondary (0°12) | 5+ | | sician | | | м | edical | | |
| 힏 | al Hy al Hy f oth | Be | 17. Father's Name (First, Middle, Last) | | 200 | | 18. Mothe | r's Name (First, Midd | | | | _ |
| yla | Ment Ment arkac | 2 | Francisco Solano M | latheus | | | Ati | lana Pinto | _ | | | |
| Maryland 21215-0036 | nit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan artiment of Health and Mental Hygiene. artiment of Health and Mental Hygiene. The straint if item 27 is marked other than "natural", or iteme 23e or 28a-f ehow injury parother treumatic event, it a Modical Examinant must be notified at e. | 7.0 | 19a. Informant's Name/Relationship (T) | rpe, Print) | 19b. Maili | ng Address (Stre | et and Numbe | r or Rural Route Nur | nber, City | or Town, State, Zip | o Code) | |
| | l and fealth m 27 her ti | 1 | Gustavo Matheus | So | n 10308 | Detric | k Aveni | ıe Kensin | | | | |
| Baltimore, | To His | | 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ F | Removal from Sta | 20b. Place of Dispondentery, creed to Metropol: | natory or other p | olace) | Date | 20c. L | ocation - City or To | own, State | |
| tim | rtmen rtant | | `4 □ Donation 5 □ Other (Specify) | | • | Cremato | ry No | v.15,2005 | Ale: | xandria,V | /irginia | |
| Bal | parmit. Pages 1 and 2 Department of Health a Important: If item 27 it any injury progher tre once. | | 21. Signature of Funeral Service Licens | 90 | (F1 | 2. Name and Add ancis J | . Coll | ins Funera | 1 Hor | me, Inc. | | |
| | | | 23a. Part1. Enter the disease, or compl | ications that caus | 50 | <u>)O Unive</u> | rsity H | Slvd.W.S | ilve: | r Śpring | | - |
| | 32 | | shock, or heart failure. List only of | ne cause on each | ine. | tel the mode of c | ying, such as | ardiac or respiratory | arrest, | | Approximate Interval Between Onset and Death | |
| | Pnysician /Medical | | disease or condition resulting in death) | | age Alzheime | r's Dis | ease | | | | 6 years | |
| | Examiner | | | Due to (or | as a consequence of): | | | | | | | |
| | | e | Sequentially list conditions, if any, leading to immediate | Due to (or | as a consequence of): | | | | | | | |
| | outed Id ansit | Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | | | | | | | | | |
| ó | be executed sician and burial-transit | EX | resulting in death) Last | Due to (or | as a consequence of): | | | | | | | |
| 8760, | cate be executed physician and the burial-transit | dical | | d | | | | | | | | |
| Φ | | Mec | IF FEMALE: | | | | | | | 1 | | |
| Вох | death certifi e attending J d for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | | 2 Fetal death 3 | Ectopic pregna | псу | | | 23d. Date of delive Month | ery Day Year | |
| o. | t the de by the a tachad i | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 □ Pregnant 9 □ Unknow | | Other (specify) | | | | Monat | Day Toal | |
| <u>α</u> | that the ed by detact | | Part II. Other significant conditions con | tributing to death | n but not resulting in the u | nderlying cause | niven in Part I | 23a. Dia | i tobacco | use contribute to the | he cause of death? | |
| Vital Records, | requires that aen signed b nould be deta | d by | Intracranial Hem | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 9 | | Yes 2 | | pably 4 Unknown | |
| 202 | w requir baen sl should | lete | | | Dergares | | | 24a. Wt | | | | |
| Re | The law ate has b page 2 sf | Completed | | | | | | au | opsy formed? | prior to condeath? | ppsy findings available mpletion of cause of | |
| tal | (0 | o C | 25. Was case referred to medical | | | | 00 Disease | 1 Yes | | 1 ☐ Yes | 2□ No | _ |
| > | Physicien: this certific al director, | 0 8 | examiner? | lospital: 1 □ Inpa | ttient 2 ☐ ER/Outpatier | it 3 DOA | thor | of Death <i>(Check only</i> sing Home 5 ☑ Re | | 6 Other /Specif | 5c) | - |
| J of | | n: T | 27. Manner of Death | 28a. Date of I | | 28c. in | | 28d. Describe | | | <i>y</i> / | - |
| io | Attending I r death. ector: After by the funer | atio | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (WOTH), | Say 7 Gary Injury | | ☐Yes 2☐N | ło | | | | |
| Division | or Attenation after death Director: in by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of building, | Injury - At home, farm, streetc. (Specify) | eet, factory, offic | е | 28f. Location City or T | (Street ar | nd Number or Rura | Il Route Number, | |
| | itel or irs afte rei Dir led in | | | | | | | ŀ | | | | |
| | To the Hospitel or Al within 24 hours after o To the Funerel Direc completely filled in by | edicai | (Check only 2 Medical Exami | sician: To the be ner: On the basis | st of my knowledge, deat of examination and/or in | occurred at the | time, date and | place, and due to the | e cause(s |) and manner as st | tated. | |
| | To the H within 24 To the Fu | Med | one) 29b. Signature and title of pertifier | and manner | stated. | | nse number | | | | | _ |
| | F ≥ F Q | | 255. Signature and title of pertiner | 1 had | 111 | 250. LICE | nua number | | ∠au. Da | te signed (Month, | vay, rear) | |
| 1 | 0 | | Trulle A | Mari | un Mi) | | 1460 | | Nove | mber 11. | 2005 | _ |
| , | | | 30. Name and address of person who co | | | | | IT | | 000 | | |
| | Sta | te | Francisco A. Mathe 31. Date filed (Month, Day, Year) | | | orgia A | venue | Wheaton,M | 20 | 1906 | | |
| 10 | Registr | | NOV 14 20 | 05 | strar's Signature | 3488/ | | | | | | |

DHMH 17 Rev 1/2001

Registrar

| | | | 1 - State of Mar | | artment of F | | and M | | ZU | 05 | 38422 | |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------|-------------------|-----------------|-------------------------------------|--------------------|------------------------|--------------------------------------------------|--|
| | | | Decedent's Name (First, Middle, Last) | | 7,7,704,70 01 | | | 2. Date of Death | g. No. | | 3. Time of Death | |
| | Physici | | Mildred Jeanette McKee | | | | | Month November | Day 10 | 2005 | 9:20 A M | |
| | /Medi Examir | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, o | or Location o | of Death | 110 V CIIID CT | T | nty of Death | 9.20 A | |
| | | | Homewood Retirement Cente | _ | lat i i | Lliams | nor | - | | Machi | inaton | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (| In yrs. last birthday | If Under 1 Year Months Days | If Under 2 | 24 Hrs. Min. | 8. Date of Birth (Month, Day, | Vaarl | 9. Birthp | lace (State or Foreign | |
| | Director | | 216-22-8686 ^{1□ M 2} XX | 78 Yrs. | World Days | Hours | avniri. | Dec.21,1 | .21,1926 Mary land | | | |
| | pug * | | Usual Residence of Decedent 10a. State 10b. County 1 | Oc. City, Town or L | contion | | | | | | | |
| | eho e | 5 | | • | | | | | | " | 0d. Inside City Limits 1 Yes 2 \(\)\(\)\(\)\(\) | |
| | the A | ect | Maryland Washington 10e. Street and Number | | Williamsp 10f. Zip Code | port | | 10 | - Citizana | -434/54-0 | | |
| | with | 급 | | | | 1705 | | 10 | g. Citizen (| of What Coun | try ? | |
| | eath | eral | 14338 Clear Spring Rd. 11. Marital Status 12. Was Decedent Ev. | ar in IIS 13 | | 1795 | nin2 /Sn | acifu Vac or No | 14 8 | USA lace - Americ | no Indian | |
| | fter d | E E | Armed Forces? | 7 11 0.0. | Was Decedent of H If Yes, specify Cuba | | , Puerto | Rican, etc.) | | lack, White, | | |
| 936 | urs a | by | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 No | Specify: | | | Spe | cify: W hi | + 0 | |
| 21215-0036 | 72 hours after death with the Maryland natural', or Itema 23a or 28a-1 ehow dical Examiner must be mailled at | Completed by Funeral Director | 15. Decedent's Education | 16a. Dece | dent's Usual Occup | pation | | . 1 | 6b. Kind of | Business/Ind | | |
| 215 | | ble | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | life. | kind of work done DO NOT use retired | during most d) | of work | ing | | | | |
| 2 | gien gien erth | Son | 12 | S | ales Cler | k | | | | Retail | | |
| nd | be filed tal Hygid d other event, | Be (| 17. Father's Name (First, Middle, Last) | | | 18. Mother | r's Name | e (First, Middle, Ma | aiden Sum | ame) | | |
| yla | Ment Ment arke | ပ | Leslie Summers Stenger | | | Iva | EI | len Ire | ne F | lora | | |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Itema 23a or 28a-1 ehow any injury or other traumatic event, the Midical Examina investigation any injury or other traumatic event, the Midical Examina investigation and once. | | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mail | ing Address (Street | and Number | r or Rur | af Route Number, o | City or Tow | m, State, Zip | Code) | |
| | and ealth m 27 | 1 | James L. McKee - Son | | Gruber R | Rd. CI | | | | 722 | | |
| Baltimore, | Pages 1 nent of H int: If Ite iry or ott | | 20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State | 20b. Place of Disp cemetery, cre | osition (Name of matory or other plac | ce) | | Date 20 | Dc. Location | n - City or To | wn, State | |
| Ë | E E E | | ' 4 ☐ Donation 5 ☐ Other (Specify) | | Mem. Par | | | | Iliam | sport, | Maryland | |
| 3all | permit. Departr Imports any inju | | 21. Signature of Funeral Service Language | | sborne agre | | | - | | | | |
| _ | € 0 7 g ol | | (un / d Al | | 25 S. Con | | | | | port,M | D 21795 | |
| | | | 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. | death. Do not en | ter the mode of dyin | ng, such as o | cardiac o | or respiratory arres | it, | | Approximate Interval Between | |
| | Physician | | Immediate Cause (Final disease or condition | 1) | mon to | | | | | | Onset and Death | |
| | /Medical Examiner | | resulting in death) Due to (or as a continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continu | onsequence of). | Cocilo | | | | | (| - Car | |
| | | _ | Sequentially list conditions, b. | | | | | | | | | |
| | ed isit | ine | riany, leading to immediate cause. Enter Underlying Cause, Cleade or injury that initiated events cause. | onsequence or): | | | | | | | | |
| | and and II-trar | Examiner | that initiated events c. resulting in death) Last Due to (or as a c | onsequence of): | | | | | _ | | | |
| 8760, | cate be executed physician and the burial-transit | a E | | | | | | | | | | |
| 687 | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | dlcal | d. | | | | | | | | | |
| × | leath certific attending pl | /Me | IF FEMALE: 23c. If yes, outcome of | pregnancy | | | | | 234 [| Date of deliver | | |
| Вох | atter f for u | Physiclan/M | in the past 12 months? | Fetal death 3 | Ectopic pregnancy Other (specify) | 1 | | | | | y Day Year | |
| o. | that the de led by the detached | ysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown | | e. (<i>9,</i> 200., <i>y</i>) | | | | 1 | | | |
| ٩ | res that igned b be deta | y P | Part II. Other significant conditions contributing to death but r | ot resulting in the u | nderlying cause giv | en in Part I. | | 23e. Did toba | cco use co | ntribute to the | a cause of death? | |
| rds | quires n sign | d by | Dictales Welliter Tratt | · | | | | 1 🗆 Yes | 2 No | 3 🔲 Proba | bly 4 □Unknown | |
| Records, | w requir | lete | Haracker win Constitute | Cartist | 200 | | | 24a. Was an | 241 | Were auton | sy findings available | |
| Re | he law e has age 2: | Completed | Type water | nova | MAKE | | | autopsy performe | d? | prior to com death? | pletion of cause of | |
| | | Č . | 25. Was case referred to medical | | | OC Disease | of Doods | | No | 1 Yes 2 | 2 No | |
| > | | 0 8 | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient | 2 ER/Outpatie | nt 3 DOA Oth | 00 | | (Check only one) me 5 ☐ Resident | ra 6 🗆 O | ther (Specific | | |
| | E = E | \vdash | 27. Manner of Death 28a. Date of Injury | 28b. Time o | f 28c. Injun | y at | - | 28d. Describe how | | | - | |
| ion | Attending I ir death. ector: After by the funer | atlo | 1 Natural 5 □ Pending (Month, Day Y 2 □ Accident investigation | ear) Injury | Worl M 1 □ | k? Yes 2⊟N | lo | | | | | |
| Division | l or Attendi after death. Director: A in by the fu | ific | 3 ☐ Suicide 6 ☐ Could not be 28 e. Place of Injury | - At home, farm, st | reet, factory, office | | - 3 | 28f. Location (Street | et and Nun | nber or Rural | Route Number, | |
| | safter safter at Direct | Certification: | 4 Homicide determined building, etc. (| эрөспу) | | | | City or Town, | Siale) | | | |
| | To the Hospital within 24 hours a To the Funeral I completely filled | | 29a. Certifier Certifying Physician: To the best of m | ny knowledge, deat | h occurred at the tin | ne, date and | place, a | and due to the cau | se(s) and r | nanner as sta | ted. | |
| | he H in 24 he F plete | edlcal | (Check only one) 2 Medical Examiner: On the basis of examiner and manner states | amination and/or in | vestigation, in my of | pinion, deatr | n occurr | ed at the time, date | and place | , and due to t | the cause(s) | |
| | with To I | Σ | 29b. Signature and title of certifier | | 29c. License | e number | 0 | 290 | I. Pate sign | ned (Month, D | ay, Year) | |
| 1 | Z; | | | | | 660 | 0 | 6 11 | ar | be// | 2005 | |
| 7 | 1 | | 30 Name and address of bereon who completed cause of deat | (Item 23a) (Type, | Print) | L | / | 1/- | /. | 2 | 1 | |
| | ` | | (MUS; KM) /4 > NO | 1 Hon | Nouse | 2 14 | age | 15 Kahu | W | 121 | 142 | |
| | Sta | | 31. Date filed (Month, DTY, Year) 32. Registrar's | Signature 4. | 1 | | | | | | | |
| | Registr | ar | NOV 1 4 2005 Agreem | 1. B. P. | serles | | | | | | | |

| | | | 1 - For State Registrer | State of Maryla | | | of Health a of Death | and M | fental Hygier | $Z \coprod \coprod$ | 5 3 | 8423 |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------|-----------------------------------|---------------------------------------|------------------------|---------------------------------------------------|-----------------------|--------------------------------------------------------|------------------------------------|
| | , | - | 1. Decedent's Name (First, Middle, Last, |) | | | | | 2. Date of Death | | 3. | Time of Death |
| 1 | Physic /Medi | | LAWRENCE MICHA | EL MURPHY, | JR. | | | | November | 3 20 | Year 05 20 | 005 ^M |
| | Exami | ner | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Tow | vn, or Location of | of Death | | 4c. County o | | |
| | | _ | 5680 Black Walnu | | | | hman Is | land | | Talb | | |
| н | FuneralDirector | | 5. Social Security Number 6. Security Number 1214-33-9081 | 7. Age (In y | rs. last birthday) Yrs. | If Under 1 Y Months Da | ear If Under ays Hours | Min. | 8. Date of Birth (Month, Day, Yea JUN 24 19 | 101 | Country) | (State or Foreign |
| | | | Usual Residence of Decedent | | + | | | | JUN 24 19 | 91 | MARYLA | ND |
| | yland | | 10a. State 10b. County | 10c. | City, Town or Lo | cation | | | | | 10d. ln | nside City Limits |
| | e Ma | cto | MD TALBOT | | TILG | HMAN | | | | | 1 | ☐Yes 2XNo |
| | ith th | Director | 10e. Street and Number | | | 10f. Zip Cod | de | | 10g. (| Citizen of Wh | nat Country? | |
| | ath w | ra | 5680 BLACK WALNU | | | 2 | 1671 | | | | USA | |
| | be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or itema 23a or 28a-f show event, ira Medical Exail, ar must be inclifted at | Funerai | | 12. Was Decedent Ever in Armed Forces? | | Was Decedent If Yes, specify (| of Hispanic Ori Cuban, Mexican | gin? (Spe i, Puerto | acify Yes or No- Rican, etc.) | | American Inc. White, etc. | dian, |
| 36 | irs aff | by F | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 □ Yes 2 📉 No If Yes, Give Year or Dates: | | 1 🗆 Yes 2 X | No Specify: | | | Specify: | WHITE | |
| 21215-0036 | 2 hou | | 15. Decedent's Edu | cation | 16a. Deced | dent's Usual Oc | ccupation | | 16b. | 1 | iness/industry | , |
| 215 | within 72 ene. then nat | pie | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | (Give | kind of work do DO NOT use re | one during most etired) | of worki | ng | , | | |
| 21 | filed wit Hygiene other the | Completed | 8 | 0 | | STUDENT | r | | Н | IIGH SO | CHOOL | |
| nd | be file d oth | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mothe | r's Name | (First, Middle, Maide | an Sumame) |) | |
| λ | | 2 | LAWRENCE MICHAEL | | | | | | LOMAX | | | |
| Maryland | - e s | 0 8 | 19a. Informant's Name/Relationship (Ty | • | | | | | l Route Number, City | | | |
| di. | s 1 and 2 if Health item 27 i | | LAWRENCE MICHAEL 20a. Method of Disposition | | . Place of Dispo | | | | 4.99 | | | |
| Baltimore, | 0 0 | | 1 Burial 2 □ Cremation 3 □R | emoval from State | cemetery, cren | natory or other | place) | | 200. | | ity or Town, S | |
| Ξ | permit. Pag Department important: I eny injury o | 1 5 | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License | | LLGHMAN | | AL CEM ddress of Facility | | /9/2005 T | ILGHM | M, MAF | RYLAND |
| Ba | Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Depermine Deperm | 0 | | MERCER | ~ FE | LLOWS. | HELFEN | BEIN | & NEWNAM | FUNER/ | L HOME | E PA |
| | X.8. | Ý | 23a, Part1, Enter the disease, or compli | cations that caused the de | | or the mode of | dying, such as o | ST I | EASTON, MD | 21601 | | oximate |
| | Pnysician | | Immediate Cause (Final | ne cause on each line. | 6 . | , | | | , | | Inten | val Between et and Death |
| | /Medical | | disease or condition resulting in death) | Due to (or as a c) ns | adhance on | (YILL) | | | | | - | |
| ٠. | Examiner | | I . | 91 | 343033 | | | | | | | |
| 1 | | Je | Sequentially list conditions, if any, leading to immediate | Due to (or as a cons | equence of): | | | | | | | |
| | death certificate be executed e attending physicien and d for use as the burial-transit | Examin | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | |
| Ő, | e exe | | resulting in death) Last | Due to (or as a cons | equence of): | | | | | | | |
| 8760, | icate be execute physicien and s the burial-trans | dical | | | | | | | | | | |
| 9 | leath certific attending p | /Me | IF FEMALE: | 2-14 | | | | | | | | |
| Вох | attend for us | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcome of preg 1☐Live birth 2☐Fe | etal death 3 | Ectopic pregna | | | | 23d. Date of Month | | Year |
| o. | that the de ed by the a detached | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at time of 9□Unknown | rdeath 5 | Other (specify | ′) | | | | . Juy | 1041 |
| <u>α</u> | that led by deta | -P | Part II. Other significant conditions con | tributing to death but not r | esulting in the un | derlying cause | given in Part I. | | 23e. Did tobacco | use contrib | ute to the cau: | se of death? |
| Vital Records, | requires that een signed b nould be deta | d by | | | | | | | | ¥ | | 4 ∐Unknown |
| 00 | w requir | Completed | | | | | | | 24a. Was an | | | |
| Re | The law ate has b page 2 st | шс | | | | | | | autopsy performed? | prio | or to completic th? | idings available on of cause of |
| <u>ta</u> | | Be C | 25. Was case referred to medical | | | | 26 Diana | of Do-th | Check only one | o 1 X | Yes 2□N | lo |
| | × 5 | ToB | examiner? 1 √ Yes 2 □ No H | ospital: 1 Inpatient 2 | ☐ ER/Outpatient | 3 □ DOA | 04 | | ne 5 Residence | 6 NOther | (Sagaifu) C | 2020 |
| 0 | ig Ph ter th | | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | | 28c. Ir | njury at Work? | | 8d. Describe how inju | | L 1 1 | cene |
| Division of | Attending F r death. ector: After by the funera | Certification; | 1 ☐ Natural 5 ☐ Pending 2 M Accident investigation | 11-3-05 | | | Yes 2 □ N | lo S | J . 1 | rum | Tangled | n |
| <u>≅</u> | or Att | Ħ | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At building, etc. (Spe | home, farm, stre | et, factory, offi | сө | 2 | 8f. Location (Street a City or Town, Sta | nd Number | -/ | e Number wat |
| | itai o irs af rai D | | | | A A . | me | | P | J. + al | sh man | 1 sland | MD |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | edicai | Check only 21X Medical Examin | ician: To the best of my k | nowledge, death nation and/or inv | occurred at the | e time, date and ny opinion, death | place, a | nd due to the cause/ | ol and mann | ar an atatad | ause(s) |
| | thin 2 the mplet | Med | 29b. Signature and title of certifier | and manner stated. | | | ense number | | | | | |
| | o Twitt | | | | | | | | | | Month, Day, Y | , |
| 1 | | - | | | 00 \ 75 | | CME | | Nove | ember, | 4, 20 | 05 |
| | 2) | | 30. Name and address of person who con | mpleted cause of death (It | ет 23а) (Туре, Р | | Ponn S+ | reat | Baltimo | ro Ma | mul and | 21.201 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Sig | nature | | TCIII OL | reet | Dat (TINO) | e, ria | тутани | 414VI |
| 150 | Registr | | NUV 0 7 20 | NJ ANDREAD | M A | Back! | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 05 38424 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 8, 2005 Physician Katherine Elaine Miller 4:00 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 480 Cove Road Accident Garrett If Under 24 Hrs.
Hours Min.
July 26, 1920 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🕱 F 219-07-3750 Director 85 Maryland Usual Residence of Decedent the Maryland worle 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other than "natural", or iteme 23a or 28a-f ehov treumatic event, tre Medical Examinar invist be notified al 1 Yes 2 No Director MD Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 108 Main Street Extended death v 21520 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Year or Dates: WW2 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Il Hygiene. College (1-4or 5+) Secretary Clerical 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: if item 27 is marked oth eny lighty or other treumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Henry Herman Miller Irene Schlesinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Shane/Niece 480 Cove Rd., Accident, MD 21520 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Country Side Crem. Nov. 9,2005 Davidsville, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. eurosce P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Pneumonia 2 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and if or use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Dementia, Senile onset 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Inanition due to dementia 24a. Was an has autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2X No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Niece's Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☐XNo 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier The Certifying Physician: To the best of my knowledge, dean occurred at the time, date and place, and due to the cause(s) and manner stated.

Left provided Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D0025759 November 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, MD, P.O. Box 247, Accident, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2005 Registrar

| | | | 1 - For State Registrar | State of Maryland / Depa | artment of Health and M | ental Hygie | ZUUD | 38425 |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------|---------------------------------------------|
| | q | | 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death | | 3. Time of Death |
| | Physic /Medi | | Maria | Mitchell | | Month November | 3, 2005 | 12:18PM ^M |
| | Examir | | 4a. Facility Name (If not institution, give s | treet and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| | | | 8382 Fishing Isla | and Road | Upper Fairmount | | Somerse | |
| | Funeral Director | | 5. Social Security Number 6. Sex | M 2XF | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Ye | | place (State or Foreign intry) |
| | | | Usual Residence of Decedent | 64 | - 4 | 12-26-194 | 1 Germ | any |
| | yland | | 10a. State 10b. County | 10c. City, Town or Lo | ocation - | | | 10d. Inside City Limits |
| | e Ma | ctor | MD Somerse | t Upper Fa | airmount | | | 1 Yes 2 No |
| | or 28 | Olre | 10e. Street and Number | | 10f. Zip Code | 10g. | Citizen of What Cou | intry? |
| | ours after death with the Marylar elf, or Items 23a or 28a-f show Examinating the Letter of the Jul | Funeral Director | 8382 Fishing Isla | | 21867 | | USA | |
| | er de | nue | | Was Decedent Ever in U.S. Armed Forces? | Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F | cify Yes or No- Rican, etc.) | 14. Race - Ameri Black, White | |
| 36 | rs aft | by F | 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced | 1 □ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 No Specify: | | Specify: Whi | . |
| Ö | | ed | 15. Decedent's Educ | ation 16a. Deced | dent's Usual Occupation | 166 | o. Kind of Business/Ir | |
| 215 | within 72 ene. than "na | Completed | (Specify only highest grade Elementary/Secondary (0-12) | completed) (Give | kind of work done during most of workir DO NOT use retired) | ng | 5. King of Dusinosari | idadiiy |
| 21 | giene. | mo: | 10 | | nemaker | | Own Home | |
| pu | be filed within 72 hartal Hygiene. d other than "naturesvent, he Medical | Be (| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name | (First, Middle, Mai | den Sumame) | |
| yla | | ှင | Emil Schneider | | Maria Sch | nneider | | |
| <u>lar</u> | C1 (0) (0) | | 19a. Informant's Name/Relationship (Typ | pe, Print) 19b. Mailin | ng Address (Street and Number or Rura | Route Number, Ci | ity or Town, State, Zi | o Code) |
| Baltimore, Maryland 21215-0036 | s 1 and if Health item 27 other tr | | Klaus Mitchell/Hus | band 8382 20b. Place of Dispo | Fishing Island Roa | | | |
| وّ | Pages nent of h int: If ite | | 1 ☐ Burial 2 Cremation 3 ☐ Re | emoval from State cemetery, cren | natory or other place) | | : Location - City or T | own, State |
| Ē | it. Partition rither rither njury | | 4 Donation 5 Other (Specify) | Salisbur | y Crematory 11/5/2 | 2005 Sal | lisbury, M | iaryland |
| Ba | permit. Pages Department of I Important: If ite eny injury or or | (| 21. Signature of Funeral Service Ucense | Hi | Name and Address of Facility Inman Funeral Home | | | |
| | | | 28a, Part1, Enter the disease, or complic | M00295 11 | 673 Somerset Ave. | Princes | s Anne, M | D 21853 Approximate |
| | :. | | shock, or heart failure. List only on Immediate Cause (Final | eations that caused the death. Do not enter a cause on each line. | I all mode of dying, such as cardiac of | respiratory arrest, | | Interval Between Onset and Death |
| | Physician /Medical | 1 | disease or condition resulting in death) | - Men as alle | my la | | | 2 Ms |
| | Examiner | | | Due to (or as a consequence of): | | | | , |
| | | Je. | Sequentially list conditions, if any leading to immediate | Due to (or as a consequence of): | | | | |
| | cuted id ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | |
| ó | an ar irial-t | | resulting in death) Last | Due to (or as a consequence of): | | | | |
| 8760, | icate be executed physician and the burial-transit | dlcal | d. | | | | | |
| 9 | ing pl | Med | IF FEMALE: | | | | | |
| Вох | death certifi e attending I id for use as | Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? | | Ectopic pregnancy | | 23d. Date of deliver | ery Day Year |
| | the a | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4☐Pregnant at time of death 5☐ 9☐Unknown | Other (specify) | | Worth | Day real |
| ٥. | The taw requires that the do the has been signed by the page 2 should be detached | | Part II. Other significant conditions cont | ributing to death but not resulting in the un | oderwing cause given in Part I | 23e Did tobaco | co use contribute to the | he cause of death? |
| Records, | uires tha signed l d be det | d by | | nothing to could be not recording in the dr | addinying dadab giver in hait i. | 1 ☐ Yes | | |
| Ö | v requii been s should | ete | | | | - | | |
| Rec | The tav ate has page 2 | Completed | | | | 24a. Was an autopsy performed | prior to co | psy findings available mpletion of cause of |
| | | e Co | 25. Was case referred to medical | | | performed | No 1 ☐ Yes | 2 No |
| | Physicien: this certific ral director, | OB | examiner? | ospital: 1 Inpatient 2 ER/Outpatient | 26. Place of Death t 3□ DOA Other: 4□ Nursing Hom | . / | 0.50 | |
| | g Phy er this eral c | H-16 | 27. Mapner of Death | 28a. Date of Injury 28b. Time of | 28c. Injury at 28 | Bd. Describe how in | 6 ☐Other (Specification) | у) |
| 0 | Attending I r death. ector: After by the funer | atlo | 1 ✓ Netural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) Injury | Work? M 1 ☐ Yes 2 ☐ No | | | |
| Division | r Atte er de recto by th | tific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, farm, stre building, etc. (Specify) | eet, factory, office | Bf. Location (Street City or Town, St | and Number or Rura | I Route Number, |
| | tal or rs aft el Dii ed in | Certification; | | building, old. (Opadily) | | City of Town, 3t | ate) | |
| | To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer | Medical | 29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin | cian: To the best of my knowledge, death sr: On the basis of examination and/or inv and manner stated. | occurred at the time, date and place, ar estigation, in my opinion, death occurred | nd due to the cause d at the time, date a | e(s) and manner as s and place, and due to | tated. the cause(s) |
| | o the ithin o the omple | Mec | 29b. Signature and tyle of certifier | and manner stated. | 29c. License number | 29d. I | Date signed (Month, | Dav. Year) |
|) | ⊢ s ⊢ ŏ | | 1 RUNIN | 111 | DIATOR | 1 | 1/4/15 | |
| | | | 30. Name and address of person who con | rpleted cause of death (Item 23a) (Type F | Printh Printh | | 1 .103 | |
| | | | July h H. Grasse | 12.0 | Corroll St A.1 | Scilisti | iry MD 21. | 801 |
| • • • | Sta | | 31. Date filed (Month, Day, Year) | 32. Register's Signature | 1 4 | | | |
| | Registr | ar | NOV 15 | 2005 Slew & | BONE | | | |

| | • | 1 - For State Registrar aMFND i | TEM #8 pER f | aryland / Dep h g850 1 2 % | | | | Reg. No. 005 | 38426 |
|-------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------|------------------------------------------|---------------------------------------------|----------------------------------------------|---------------------------------------------------------|
| Physici | an | T. Decedent's Name (First, Mide | Ne, Lasij | | | | 2. Date of Dea | | 3. Time of Death |
| /Medic | al | Charles 4a. Facility Name (If not institution | Herbert | Moore | 4h City Town o | Sr. r Location of Death | | , 2005 4c. County of E | 5:00 am |
| Examin | er | 1424 Church | | | Cumbe | | | Allegar | |
| uneral rector | | 5. Social Security Number 187-18-6921 | 6. Sex 7. Ag | e (In yrs. last birthday 89 Yrs. | Months Days | If Under 24 Hrs. Hours Min. | May 2 | 3,°1916 | Birthplace (State or Foreign Country) |
| A II | | Usual Residence of Decedent 10a. State 10b. Count | • | 10c. City, Town or L | | | 2.2 | <u>. </u> | 10d. Inside City Limits |
| tilled | ctor | MD All | egany | Cum | berland | | | | 1 □ Xes 2 □ No |
| event, the Medical Examiner must be notified at | Funeral Director | 10e. Street and Number 1424 Church S | Street | | 10f. Zip Code | 21502 | | 10g. Citizen of Wha | · · |
| Cmust | erai | 11. Marital Status | 12. Was Decedent | Ever in U.S. 13. | Was Decedent of H | | pecify Yes or No- | - 14. Race - A | American Indian, |
| Examina | | 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce | If YAs Give | | 1 Yes 2 No | Specify: | o Rican, etc.) | 0 | white white |
| BSICE | etec | 15. Decede (Specify only high | nt's Education est grade completed) | (Give | edent's Usual Occup | durina most of wor | rking | 16b. Kind of Busine | ess/Industry |
| | Completed by | Elementary/Secondary (0-12) | College (1-4or | 5+) | DO NOT use retired rintendent | 3) | | Union Ca | rbide Co. |
| vent, | BeC | 17. Father's Name (First, Middle | | | | | | Maiden Surname) | |
| | 2 | Joseph Eug | | | | | | <u> </u> | ore Bowman |
| other traumatic | | 19a. Informant's Name/Relation Louetta Moore | | 142 | 24 Church | Street | Cuml | er, City or Town, Stat berland | MD 21502 |
| _ | | 20a. Method of Disposition 1 ☐ Durial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (| | | osition (Name of Imatory or other place O Veterans' C | | 11/23/200 | 20c. Location - City 5 Flintston | |
| once. | | 21. Signature Funeral Service | Licensee | $M^{\frac{1}{2}}$ | 2. Name and Addre Scarpe 108 Vir | iii Funeral H | Home, P.A. | rland, MD 21 | 1502 |
| | | 23a. Part 1/Enter the disease, of shook, or heart failure. Lis | or complications that caused it only one cause on each li | the death. Do not en | | | | | Approximate Interval Between |
| ian cal | | Immediate Cause (Final disease or condition resulting in death) | - u. | TIVE HEART | FAILURE | | | | Onset and Death |
| ier | | | | a consequence of): | ACCIDENT | | | | |
| ų | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b | a consequence of): | | | | | |
| ĺ | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | G | PULMONARY a consequence of): | ARREST | | | | |
| | dicai E | | d | | | | | | |
| for use as (| /Med | IF FEMALE: | 23c. If yes, outcome | of pregnancy | | | | 0015. | |
| teched for u | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | 2 Fetal death 3 | □Ectopic pregnancy □ Other (specify) | | | 23d. Date of Month | Day Year |
| alen en Dinous | þ | Part II. Other significant condit | ions contributing to death b | ut not resulting in the t | underlying cause give | en in Part I. | 23e. Did to | V | e to the cause of death? Probably 4 Unknown |
| | Completed | | | | | | 24a. Was autop | sv prior | autopsy findings available to completion of cause of |
| r, page | | | | | | | perfor 1 ☐ Yes | rmed? deat | h? Yes 2□ No |
| director, | To Be | 25. Was case referred to medic examiner? 1 Yes 2 X No | Hospital: | ent 2 ☐ ER/Outpatie | nt 3□ DOA Oth | | th Check only of | <i>ne)</i> lence 6 ⊡Other <i>(5</i> | Property |
| funeral | | 27. Manner of Death 1 Natural 5 ☐ Pend | 28a. Date of Inju | | | | - / | ow injury occurred | эрвину) |
| | icati | 2 Accident invest | I not be | | M 1 🗆 | Yes 2□No | 29f Loantion /C | See as and Street are | r Rural Route Number. |
| | Certification: | 4 Homicide deter | building, et | ury - At home, farm, st c. (Specify) | reet, factory, office | | City or Tow | in, State) | r Hurai Houte Number, |
| completely fitled in by the | ledical C | 29a. Certifier Certify (Check only one) 2 Medica | ing Physician: To the best I Examiner: On the basis o and manner st | t examination and/or in | th occurred at the time envestigation, in my of | ne, date and place pinion, death occu | , and due to the or rred at the time, or | cause(s) and manne date and place, and | r as stated. due to the cause(s) |
| Ē | Me | 29b. Signature and title of certifi | er / | | 29c. License | e number | | 29d. Date signed (M | onth, Day, Year) |
| 3 | | | | | | | . | 1// | |
| . 8 | | 1 (Son | / | | | 00062429 | | 11/21/ | 05 |
| 2 8 / } | | 30. Name and address of person | | | | | | 11/2// | 05 |

| Physician / Wedical Examiner 1. Decedent's Name (First, Middle, Last) Willard Holmes Nogle 4. Fecility Name (If not institution, give street and number) 56 White Church-Steyer Rd. 6. Sex 7. Age (In yrs. /ast birthday) Months Day Hours Min. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 6: 30 at 4c. County of Death Garrett Funeral Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. /ast birthday) Months Days Hours Min. Month, Day Year Months, Days Hours Min. 7. Age (In yrs. /ast birthday) Months Days Hours Min. Month, Day Year Month, Day Year Till Month, Day Year Months, Days Hours Min. Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day Year Till Month, Day | | 1 - State of Marylan | d / Departmen Certificat | t of Health a | and Mental H | ygiene () | 5 384 | 27 |
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| P. Daniel Miller 69 Wolf Acres Dr. Oakland, MD 21550 | | Versiones price | m 92a) /Tyma Print) | 1120174 | | 210 1 1 2 9 | | |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 4, 2005 **Physician** 7:30 P.M Maxwell Otto Lorraine Miriam /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Anne Arundel Marley Neck Nursing & Rehab. Glen Burnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay Year) | 9. Birthplace (Str. Country) | August 18,1910 | Florida Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2√2 F 95 216-12-8942 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is merced other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaninal must be notified at 1 ☐ Yes 2X No Odenton Anne Arundel Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21113 1112 Annapolis Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married SpecifyWhite Maryland 21215-0036 1 ☐ Yes \$ TVNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Elizabeth Smith Thomas Leonard Maxwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. 423 14th St., Unit 306K Ocean City, MD 21842 John H. Otto (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Nov.9,2005 Baltimore, MD 21. Signature of Fuyera Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Services M00982 42 Hudson St. Suite 110 Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter the critical Cause (Disease or injury Due to (or as a consequence of) Examine physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 (XINO certificate 26. Place of Death Check only one 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 8, 2005 D-40521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Hospital Drive DR OTHINE Barnie, MD 21061 nen. 32. gistrar's Signature 31. Date filed (Month, Day, Year) NOV 0 9 State 2005 Registrar

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| the contract of | Physici | | 1. Decedent's Name (First, Middle, Last) Donald O'Reilly 2. Date of Death Month Day Again 2. Date of Death Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again Day Again |
| - | /Medic Examir | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Accounty of Death |
| | Funeral Director | | 5. Social Security Number 6. Sex 192–18–0203 7. Åge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 Hours Min. 4 Hours 4 Hrs. 8. Date of Birth (Month, Day, Year) 4 Hours 4 Hrs. 8 Date of Birth (Month, Day, Year) 4 Hours 4 Hrs. 8 Date of Birth (Month, Day, Year) 4 Hours 4 Hrs. 8 Date of Birth (Month, Day, Year) 4 Hours 4 Hrs. 8 Date of Birth (Month, Day, Year) 5 Hours 4 Hrs. 6 Hours 4 Hrs. 8 Date of Birth (Month, Day, Year) 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 Hrs. 6 |
| | aryland | _ | Usual Residence of Decedent 10a. State |
| | ith the Ma or 28a-1 | Directo | MD. Allegany Westernport 10g. Citizen of What Country? 22518 Minnetonka Ave. 21562 United States |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-1 ehow pay injury or other traumatic event, the Medical Exam one or unit be positived at ance. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Maridowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 |
| 21215-0036 | s within 72 ho jiene. r then "natur the Medical. | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician 16b. Kind of Business/Industry Railroad |
| Maryland 2 | uid be filed fentai Hyg rked othe tic event, | To Be C | 17. Father's Name (First, Middle, Last) Richard O'Reilly 18. Mother's Name (First, Middle, Maiden Sumame) Sara Tower |
| | nd 2 shou aith and N 27 is mai ir traumai | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald O'Reilly/ son 22518 Minnetonka Ave, Westernport, Maryland 21562 |
| timore, | Pages 1 a nent of Hes int: if item iry or othe | | 20a. Method of Disposition **Posturial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peters Cemetery 2005 20c. Location - City or Town, State Westernport, Maryland |
| Balti | permit. Departnimports eny inju | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562 |
| · · · · · · · · · · · · · · · · · · · | Physician /Medical Examiner | | 23a. Pant. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): |
| 8760, | ficate be executed physician and is the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): |
| O. Box 6 | The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 |
| ٥. | uires that n signed b ld be deta | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| Division of Vital Records, | | Completed | 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No |
| <u> </u> | Physicien: Th r this certificate ral director, pag | To Be | 25. Was case referred to medical examiner? 1 |
| ion of | nding Phy ath. r: After this e funeral c | | 27. Manner of Death 1 |
| Divis | al or Attends after death | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Ipidity At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune | edical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
| | To the within To the comple | Σ | 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) |
| , | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |
| | Sta Registr | | Dr. Vikramaditya Poonai 924 Seton Drive Comberland, Haryland 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature |
| 46) | | | MON T # 5000 |

| | | . For | State of Marylar | nd / Dep | | ealth and | • | ene | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------|---------------------------------------|---------------------------------------------------|------------------------------------------|-----------------------------------------------------|
| | | For State Registrar | | Ce | rtificate of l | Death | | R 005 | 38430 |
| Physici | ian | 1. Decedent's Name (First, Middle, Last | | | | | 2. Date of Death Month NGVEML | Day Year | 3. Time of Death |
| /Medie | cal | CHARLES PA 4a. Facility Name (If not institution, give | LMER street and number) | | 4b. City, Town, or | Location of Dea | | 4c. County of Dea | |
| Exami | iei | Prince Georg | | e | che | 1 | | Prince | 6 eorge's |
| Funeral | | 5. Social Security Number 6. Se | x 7. Age (In yrs. | last birthday) | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | . (Month, Day, Y | ear) 9. Bir | thplace (State or Foreign ountry) |
| Director | | 215-03-2292 Usual Residence of Decedent | |) / ris. | | | Oct. 26, | 1968 Wasl | nington, DC |
| ryland thow | | 10a. State 10b. County | 10c. C | ty, Town or Lo | ocation | | | | 10d. Inside City Limits |
| he Ma Ba-f s | ecto | Maryland Anne Aru | ndel | Croft | | | | | 1 XYes 2 □ No |
| with t | Funeral Director | 10e. Street and Number 1482 Lowell Court | | | 10f. Zip Code | , | 109 | Citizen of What Co | ountry ? |
| death | nera | 11. Marital Status | 12. Was Decedent Ever in U Armed Forces? | J.S. 13. | Was Decedent of Hill Yes, specify Cuba | | Specify Yes or No- | 14. Race - Ame Black, Whit | |
| s after | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | 37 | Specify: | to Filoditi, Oto.) | Specify: A1 | rican |
| 2 hour | | 15. Decedent's Edu | cation | 16a. Dece | dent's Usual Occupa | ation | 16 | b. Kind of Business | nerican Andustry |
| thin 7: | Completed | (Specify only highest grad Elementary/Secondary (0-12) | e completed) College (1-4or 5+) | (Give | kind of work done of DO NOT use retired | luring most of wo) | nking | | |
| iled wi Hygien Ther th | | 12 17. Father's Name (First, Middle, Last) | | | Manager | 18 Mother's Na | me (First, Middle, Ma | Private | |
| id be fighted be fighted be fighted be fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by the fighted by t | To Be | Cyrus Lee | Palmer S | r. | | Gertrud | | | |
| Individual First 13-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "natural", or items 23a or 28a-f show reumatic event, the Medical Examinet must be notified at | - | 19a. Informant's Name/Relationship (T) | | | ng Address (Street a | and Number or R | ural Route Number, C | | Zip Code) |
| ine, intally identified within 72 hours after death with the Marylan is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at | | Vanessa R. Palmer | (Wife) | | Lowell Consistion (Name of | ourt Cr | ofton, MD | 21114 | T Civil |
| Pages 1 tment of H tant: If ita | | 20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 3 ☐ F | Removal from State | cemetery, cre | matory or other plac | | - | c. Location - City or | |
| 그 등원들 . | | * 4 □ Donation 5 □ Other (Specify) 21. Signature of Foreral Service Licens | | | 2. Name and Addres | | 14/2005 La Jordan Fund | | |
| permi Depar Impo | | 100 | H. | | | ng Road, | NE Wash: | ington, D | |
| | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | | | | | | | Approximate Interval Between Onset and Death |
| Pnysician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Dissect | ing 1 | Aortic | Aneur | ysm | | |
| Examiner | ı | | Due to (or as a conser | quence or): | | | | | |
| P ii | iner | if any, leading to immediate cause. Enter Underlying | Due to (or as a conse | quence of): | | | | | |
| xecute and I-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as a conse | quence of): | | | | | |
| The law requires that the death certificate be executed the second second as been signed by the attending physician and page 2 should be detached for use as the burial-transit | icai E | | d | | | | | N. | |
| rtificat ng phy | | IF FEMALE: | | | | | | | |
| death certifical | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feti 4 ☐ Pregnant at time of the | al death 3[| Ectopic pregnancy | | | 23d. Date of de Month | ivery Day Year |
| the de ached | Physician/Med | 1 Yes 2 No 9 Unknown | 9 Unknown | 10411 31 | Other (specify) | | | | |
| es that the death gned by the atte | by P | Part II. Other significant conditions co | ntributing to death but not re | sulting in the L | underlying cause give | en in Part I. | 23e. Did tobac | | the cause of death? |
| w requires to been signer should be. | | | | | | - | 1 ☐ Yes | | obably 4 dinknown |
| has b | Completed | | | | | | 24a. Was an autopsy performe | prior to | utopsy findings available completion of cause of |
| VICIAN: The control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o | O | 25. Was case referred to medical | | | | 26 Place of De | 1 Yes 2 ath (Check only one) | No 1 □ Yes | 2 No |
| Physician: Physician: rithis certifica | To B | examiner? | Hospital: 1. Inpatient 2 | ER/Outpatie | nt 3 DOA Othe | | Home 5 Residence | e 6 □Other (Spe | cify) |
| ding Physician: The hit. : After this certificate his stuneral director, page | ion: | 27. Manner of Death 1. ☑Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | of 28c. Injury Work | at ? | 28d. Describe how | | |
| VISIO r Attandi er death. rector: A by the fu | ertification; | 2 Accident investigation 3 Suicide 6 Could not be | 28e. Place of Injury - At h | ome, farm, st | | res 2 □ No | 28f. Location (Street | | ural Route Number, |
| tal or A | Certi | 4 Homicide | building, etc. (Speci | fy) | | | City or Town, S | State) | |
| To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edicai | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam | sician: To the best of my kn ner: On the basis of examin- and manner stated. | owledge, deat ation and/or in | th occurred at the time evestigation, in my of | e, date and plac pinion, death occ | e, and due to the caus urred at the time, date | e(s) and manner as and place, and due | stated. to the cause(s) |
| To the | Me | 29b. Signature and title of certifier | | | 29c. License | | 1 | Date signed (Mont | |
| (,) | | Salada ! | thate so | | H | 00559 | 27 No | vember | 10, 2005 |
| | - | 30. Name and address of person who c | ompleted cause of death (Ite | m 23a) (Type, | Print) | en Ch. | Neel. | uani la | 10, 2005 |
| * St | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | ature | 2170 | 1 - 2 | 144 | THE TY INTO | ~ |
| Regist | rar | NOV 1 4 2005 | eve X Ap | we. | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11/2005 FREDERICK WILLIAM PERSON 2:07PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 26525 Dulaney Road Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 11/17/ 6. Sax 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 M 2 □ F Yrs Director 218-54-8295 55 1949 Wisconsin Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Itam 27 is marked other then "natural", or Itams 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f shov tre Medical Executer right be rediffed at Funeral Director MD Somerset Crisfield 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26525 Dulaney Road 21817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Giv♣ Y Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) welder construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Philip Person Webb Nancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Person/ Brother 2928 Byrdtown Road, Crisfield, MD 21817 Itam 27 othar to 20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory 11/12/2005 Salisbury, MD 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) <u>≒</u> ö permit. Page Department of Important: If any injury or 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 103 Linden Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardies shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other siggificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Tobably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 100 Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature a 29d. Date signed (Month, Day, Year) 2 person who completed cause of death (Item 23a) (Type, Print) 32. Degistrar's Signature State Registrar

| | | | State of Maryland / Department of Health and Mental Hygiene 1 - For State State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Tro. 0 5 3 8 4 3 | | | | | | | | | | |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------|---------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------|--------------------------|------------------------------------------------|
| | Physici | | 1. Decedent's Name (First, Middle, La Alice | F | Phillips | | | | 2. Date of Death November Day, 2005 9:00P. M | | | | |
| | /Medic Examin | | 4a. Facility Name (If not institution, given Hebrew Home of Gr | er) | 4b. City, Town, or Location of Death | | | | 4c. County of Death Montgomery | | | | |
| Ī | Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic evant, the Medical Evantice must be notified at once. | | 023-01-9842 | Sex 7. A 1 □ M 2 X F | Age (In yrs. I | as <i>t birthday)</i> 92 Yrs. | If Under 1 Year Months Days | If Under a | 24 Hrs. Min. | 8. Date of Bir (Month Da April | 18,1913 | 9. Birthi Coul Mas | place (State or Foreign ntry) Sachusetts |
| | | | Usual Residence of Decedent 10a. State 10b. County | | | , Town or Lo | | | | | | | 10d. Inside City Limits |
| | | ector | Maryland Montgom | | | ckvill | 10f. Zip Code | | | | 10g Citizen of | What Cou | 1 ☐ Yes 2 ☒ No |
| | | ai Dir | 10e. Street and Number 6121 Montrose Ro | ad, #345 | - 3Wes | st | Toi. Zip code | 2085 | 52 | | united | Stat | ës |
| 036 | | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ N 1 □ Yes 2 □ N 1 □ Yes Give Year or Dates: | | | If Yes, specify Cuban, Mexican, Pur | | | gin? (Spe i, Puerto f | Specify Yes or No- rto Rican, etc.) 14. Race - A Black, V Specify: | | | |
| 15-0 | | Completed by | 15. Decedent's E (Specify only highest gr | \. F.\\ | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) | | | | king 16b. Kind of Business/Ind | | | • | |
| 1212 | | Com | Elementary/Secondary (2) College (1-4or 5+) homemaker 7. Father's Name (First Middle (ast)) | | | | | 19 Motho | r's Namo | /Eirst Middle | own home | | |
| ıland | | To Be | | | | | | | Mother's Name (First, Middle, Maiden Surname) becca Myerson | | | | l . |
| Mary | d 2 shouth and h | | 19a. Informant's Name/Relationship Jeffrey Phillips | | | | g Address (Street : John Carr | | | | | | |
| Jre, | es 1 an of Heall fitam 2 | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | | 20b. P | | sition (Name of natory or other place | | | ate | 20c. Location | | |
| II. | iit. Pagartment | | '4 □Donation 5 □ Other (Special Signature of Funeral Service Lice | ify) | Sha | | norial Pa | | | 2005 | | | sachusetts |
| Ba | Deg de de de de de de de de de de de de de | | Monald V. B | aguaro | of | 44 44 | onald vir 00 Powder | Borgw Mill | varqt L Roa | d Belt | ar nome sville, | , PA Mary | land 20705 |
| | 8760, ate be executed Waterian and whysician and the burial-transit | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition a MULTI - IN FA2CT DEMENTIA | | | | | | | | | | |
| | | | disease or condition resulting in death) | Due to (or a | as a consequ | uence of): | F.42C | 7 | EN | (ENO) | Н | | |
| | | er | Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or a | as a coustain | ience offi | | | | | | | |
| | | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequence of): | | | | | | | | | |
| 8760, | ite be ex lysician ne buria | dicai E | | d | | | | | | | | | |
| '≲ O. Box 68 | OT VITAL HECOIDS, P.O. BOX b Physician: The law requires that the death certific tribs certificate has been signed by the attending p raid director, page 2 should be detached for use as | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown | 2 🗍 Fetal at time of de | death 3 | Ectopic pregnancy Other (specify) | , | | | 131 | te of delive | ery Day Year |
| ds. P. | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | |
| Œ | | Completed | | | | | | | | 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No | | | |
| Vital 6 | | Be | 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) | | | | | | | | | | |
| jou | | on; To | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred | | | | | | | | | | |
| ADivision | uttandir death. ctor: Ai y the fu | Certification; | 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be | | | | | | | | | | |
| Öİ | Itel or Att | | 4 Homicide determined building, etc. (Specify) | | | | | | | | | | |
| | DIVISION To the Hospitel or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune | edicai | | hysician: To the be iminer: On the basis and manner | s of examina | | | | | | | | |
| | To th withir To th | × | 29b. Signature and title of certifier | | | | 29c. Licens | e number | e u | | 29d. Date signe | d (Month, | Day, Year) |
| | 10 | | 30. Name and address of person who | completed cause o | of death (Item | 23a) (Type, | Print) | (0 0 7 | ו ט | 0 | 1 1 | DCK | 03000 |
| | Sta | ite | 31. Date filed (Month, Day, Year) | ATEC A | strar's Signa |) 2 ture | Monte | عاع | icel | 1 | 10 J. / le | 141 | 120152 |
| | Registi | | NOV 10 2 | 005 | ws B | 1 100 | also I | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 6, **Physician** Franklin Kellogg Peacock 2005 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baywoods of Annapolis Annapolis Anne Arundel 7. Age (In yrs. last birthday) 86 8. Date of Birth (Month, Day Year)
April 21, 1919

9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours Min. 1**X** M 2□ F Yrs Director 220-01-1374 Usual Residence of Decedent with the Maryland 10b. Count 10c. City, Town or Location 10a, State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exeminar must be notified at 1 Yes 2 No Directo Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mode Funeral 7101 Bay Front Drive 21403 United States 12. Was Decedent Ever in U.S. Amed Forces? 1 23 Yes 2 No 1944-If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone Comptroller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Miller Peacock Julia Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5625 Brooks Woods Lothian, Maryland 20711 Julia Meadows / Daughter Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 11/8/2005 Baltimore, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatura of Funeral Service Licensee John M. Taylor Funeral Home, Inc. 1 Michay 147 Duke of Gloucester St. Annapolis, MD 21401 Many 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) cronory arter /Medical Due to (or as a on equence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 Yes 2 X No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💆 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier 1 🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) D 38958 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 208 Crain His Lugar Sw Glen Byrnie. gistrar's Signature State Registrar

| | N <u>a 1</u> | | 1 - For State Registrar 1. Decedent's Name (First, Middle, Las | State of Maryla | | artment <i>rtificate</i> | | | | Reg. No. | 005 | 38434 |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------|-----------------------------|------------------------------------------|-----------------------------------------|-----------------|----------------------------------------------|-------------------------------------------------------|
| | Physici /Medi Examir | cal | Constance Morto 4a. Facility Name (If not institution, give | n Paddock | | 4b. City. To | own, or L | ocation of De | Novembe | er 4, | 2005 County of Dea | 10:54 a M |
| *** *** | Funeral | ier | Holy Cross Hospi 5. Social Security Number 6. Se | tal 7. Age (In yr | s. last birthday) | Silv If Under 1 | er S | Spring If Under 24 H Hours M | rs. 8. Date of Birt | | Montg | |
| - | Director | or . | 128-05-1754 | □M 2X□F 9(| Yrs. City, Town or Lo | | Days | Hours IM | May 16, | 191 | L5 Ma | ssachusetts 10d. Inside City Limits 1 Yes 2 No |
| | death with the Maryland ms 23a or 28a-f ahow rmust be notified at | i Directo | Maryland Montgom 10e. Street and Number 13020 Estelle Roa | | Silver | 10f. Zip C | | | | 10g. Citi; | zen of What Co | |
| 030 | be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Itams 23a or 28a-f ahow other than "natural", or Itams 23a or 28a-f ahow avent. Ita Madical Exacting must be publised at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 □ Yes 3€ No ff Yes, Give Year or Dates: | | | nt of His y Cuban | panic Origin? Mexican, Pu Specify: | (Specify Yes or No erto Rican, etc.) | | 14. Race - Ame Black, Whit Specify: Wh | e, etc. |
| 1215-0036 | within 72 ho ene. then "netur he Medicel I | Completed | 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) | de completed) College (1-4or 5+) | (Give | | done du retired) | on ring most of w | rorking | 16b. Kir | nd of Business | |
| _ | 2 should be filed and Mental Hygie is marked other raumatic avent. It | To Be Co | 17. Father's Name (First, Middle, Last) William Morton | 2 | HO | memake | | | ame (First, Middle, | Maiden | Own Hor | me |
| поге, магу | ages 1 and nt of Health : If item 27 or other to | | 19a. Informant's Name/Relationship (T. Chester Franklin P. 20a. Method of Disposition 1 □ Burial 2X□ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | Removal from State | | Esta sition (Name matory or other | 11c of er place) | Road. | Silver Sy Date Vember 8 | ring 20c. Lo | mD 2 | 0906 Town, State |
| Daitimor | permit. Pa Department Important any injury once. | | 21. Signature of Funeral Service Licens | May | 22 | Franci 500 Un | Addrys iver | sity B | ns Funera lvd, W, S | l Ho Silve | me Inc | , Virjinia ng, MD 20901 |
| | Physician /Medical | | 23a. Park! Enter the disease, or comp shock or heart failure. List only of Immediate Cause (final disease or condition resulting in death) | lications that caused the dec one cause of each line. a. <u>Dementia</u> Due to (or as a conse | | er the mode of | of dying, | such as card | ac or respiratory ar | rest, | | Approximate Interval Between Onset and Death 10 Years |
| ,007 | cate be executed XX physicien and multiple burial-transit contractions and contractions are contracted as a contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the | dicai Examiner | it any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Congestive Due to (or as a conse Due to (or as a conse d. | Heart | Failur | e | - | | | | 10 Years |
| .O. DOX | To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. To the Fundral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown | al death 3 | Ectopic preg Other (spec | | | | 2 | 3d. Date of deli Month | ivery Day Year |
| r (spin | equires that en signed b ould be deta | by | Part II. Other significant conditions co | ntnbuting to death but not re | sulting in the ur | nderlying cau | se given | in Part I. | | | | the cause of death? |
| ים שני | n: The law re | e Completed | 25. Was case referred to medical | | | | | | 24a. Was a autop: perfor 1 Yes | med? 20 No | 24b. Were au prior to death? | topsy findings available completion of cause of 2 No |
| | To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | ToB | examiner? | Hospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year) | ER/Outpatien 28b. Time of Injury | | Other: Injury a Work? | 4 🗆 Nursing | eath (Check only or Home 5 Resid | ence 6 | | sify) |
| 2 | orial or Attaurs after de rei Directo | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At I building, etc. (Spec | ify) | | | | City or Tow | n, State) | | ral Route Number, |
| : | thin 24 ho the Fune the Fune | Medical | 29a. Certifier (Check only one) 1. Certifying Phy 2. Medical Exemione) 29b. Signature and title of certifier | sicien: To the best of my kn ner: On the basis of examin and manner stated. | owledge, death ation and/or inv | estigation, in | my opin | ion, death occ | curred at the time, d | ate and p | place, and due | to the cause(s) |
| 1 | | | CRACU AC 30. Name and address of person who co | | m 23a) /Tuna | \mathcal{I} | | 496 | | | signed (Month | |
| no. | (0) | to. | Mohammad Khalid, | | Ferrara | a Driv | e, W | heaton | , MD 2090 | 6 | | |
| | Registra | | 31. Date filed (Month, Pay, Year) | 005 | B B | and I | | | | | | |

PALMER, LEWIS 216-44-8716

| | | | 1 - For State Registrar | State of Maryland / | Department of I Certificate of | | ental Hygier | 4000 | 38435 |
|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------|------------------------------|----------------------------------------------------|
| | hysici | | 1. Decedent's Name (First, Middle, La | | Imer | 1 | 2 1 | Day Year | 3. Time of Death |
| | /Medic xamin | | 4a. Facility Name (If not institution, giv | e street and number) | 4b. City, Town, | or Location of Death | | 4c. County of Dea | ath |
| Fin | neral | | PENINSULA REGIONA 5. Social Security Number 6. S | | inthday) If Under 1 Year | MACUS BUNG If Under 24 Hrs. 8 | 3. Date of Birth | Wicon. | 1/Co rthplace (State or Foreign |
| | ector | | 2 16 44-8716 Usual Residence of Decedent | M 2□F 59 | Yrs. Months Days | Hours Min. | B. Date of Birth (Month, Day, Yea 03-6-19 | | (ARYLAND) |
| ryland | i i | | 10a. State 10b. County | 10c. City, Tow | vn or Location | | | | 10d. Inside City Limits |
| the Ma | otifle | Director | Mary land 7A/b | ot Ni | t+man 10f. Zip Code | | 100 | 0.00 | 1 Tes 217No |
| deeth with the Maryland | ast ten | al Di | 8673 Beech | ley Rd. | 2, | 1676 | log. v | Citizen of What C | ountry ? |
| fter dee | drae m | Funeral | 11. Marital Status 1 □ Never Married 2 □ Married | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of I If Yes, specify Cub | Hispanic Origin? (Speci ban, Mexican, Puerto Ri | ify Yes or No- ican, etc.) | 14. Race - Am Black, Whi | |
| 72 hours after deeth w | Exam | by | 3 ☐ Widowed 4 Divorced | 1 □ Yes 2 🛱 No If Yes, Give Year or Dates: | 1 □ Yes 2 No | | | Specify: | Black |
| within 72 tense. | Medica | Completed | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) | ducation 16a completed) College (1-4or 5+) | Decedent's Usual Occu (Give kind of work done life. DO NOT use retire | during most of working | 16b. | . Kind of Business | s/Industry |
| filed with Hygiene. | at a | | 17. Father's Name (First, Middle, Last, | | Waterma | | | Seaf | ord |
| yidii ould be f Mental h | orient intention to the traumatic event, the Madical Examiner must be notified at a. | To Be | James | Tui | ner | Lenor | 0 | en Sumame) | |
| 12 short hand h | trauma | | 19a. Informant's Name/Relationship (| | o. Mailing Address (Street | t and Number or Rural I | Route Number, City | y or Town, State, | Zip Code) |
| Jes 1 and 1 of Healt | other | | 20a. Method of Disposition | | of Disposition (Name of ary, crematory or other pla | Dat | man 20c. | No. 2/ Location - City or | Town, State |
| permit. Pages Department of Important: If It | o kunju | | 1 Surial 2 Cremation 3 C | charle | s Thomas C | em. 11-12 | -2005 51 | 1. mich | acls, md. |
| permit. Departr | any in | | 21. Signature of Funeral Sales Tices | SO | Bennie Bennie | em: 11-12 ess of Facility Sm: th Fu Ver Street | neight He | ome ome | 21601 |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final | one cause on each line. | not enter the mode of dyi | ng, such as cardiac or r | espiratory arrest, | 7 | Approximate Interval Between Onset and Death |
| | dical | | disease or condition resulting in death) | a Due to (or as a consequence | of): | | | | 1 |
| Exam | niner | <u>_</u> | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a consequence | of\. | | | | |
| cuted | ransit | Examiner | Cause (Disease or injury that initiated events | c | 017. | | | - | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death. | is the burial-transit | alEx | resulting in death) Last | Due to (or as a consequence | of): | | | | |
| ertificate ling phy | e as the | Medical | IF FEMALE: | | | | | | |
| death c | should be detached for use a | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death | 3 ☐ Ectopic pregnanc; 5 ☐ Other (specify) _ | у | | 23d. Date of de Month | livery Day Year |
| hat the d | etache | Phys | 9 Unknown Part II. Other significant conditions c | 9☐ Unknown | | | | | |
| quires ti | ed blu | ed by | renal fail | | n the underlying cause giv | /en in Part I, | 1 ☐ Yes | , | o the cause of death? robably 4 □Unknown |
| law re | e 2 sho | Completed | HTW | | | | 24a. Was an autopsy | 24b. Were a | utopsy findings available completion of cause of |
| nn: The | or. pag | e Cor | 25. Was case referred to medical | | -1000 | 00 Ph (P | performed? 1□ Yes 2⊡1 | / death? | 2 □ No |
| hysicii his cer | direct | ToB | examiner? 1 ☑ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ► R/Ou | rtpatient 3□ DOA Oth | 26. Place of Death (C | | 6 □Other (Spe | icify) |
| oding P | funera | tlon: | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | (Month, Day Year) | Time of 28c. Injur | ryat 28d rk?]Yes 2 □No | d. Describe how inj | ury occurred | |
| or Atter tier dea | completely filled in by the funeral director, page 2 | Certification: | 3 Suicide 6 Could not be determined | | | | Location (Street a City or Town, Sta | and Number or Ri | ural Route Number, |
| spital of | pellij / | | 29a. Certifier 1 ☐ ⊘ertifying Ph | ysician: To the best of my knowledge | a, death occurred at the tir | me, date and place, and | due to the cause/ | (s) and manner as | stated |
| the Ho hin 24 t | mpletely | Medical | one) 2 Medical Exam | niner: On the basis of examination an and manner stated. | d/or investigation, in my o | opinion, death occurred | at the time, date a | nd place, and due | to the cause(s) |
| 5 ₹ 5 | 8 | | 29b. Signature and title on certifier | | 29c. Licens | 58 number | 29d. D | ate signed (Mont. | ה, Day, Year) |
| (1) | | | 30. Name and address of person who | | (Type, Print) | | | | |
| 1 | Sta | te | 31. Date lived (Month, Day Xaar) | DME (a) E | = carron st | · Sa | tis buy, | wo 2 | 1801 |
| Re | egistra | ar | 140 4 7 # 5807 | A A | | | | | |

ole.

| Please Type o | r Print in | Black | Indelible | ink. | Ensure A | II Copies | Are | Legib |
|---------------|------------|---------|-----------|-------|------------|-----------|-------|-------|
| State | of Maryla | nd / De | nartment | of He | alth and N | Aental Hy | niono | |

| | Physic | 22 | 1. Decedent's Name (First, Middle, La | mrcue. | | rtificate of Roussea | | 2. Date of D | Reg. No. | 3. Time of Death |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------|---------------------------|------------------------------------------------------------------------|
| 1 | Physic /Medi | | -Michel Lee Rous | seaux- | | | | | er 04, 2 | 2005 20:05 P ^M |
| 1 | Exami | ner | 4a. Facility Name (If not institution, giv | | | 4b. City, Town, or | Location of Deal | th | 4c. Coun | ty of Death |
| | - | | 8035 Crainmount D | | de la latera | Glen Bur | | | Anne | Arundel |
| - | Funeral Director | | 5. Social Security Number 6. S 218–04–5722 | ex 7.Age OXM 2□F | (In yrs. last birthday, 28 Yrs. | Months Days | If Under 24 Hrs Hours Min. | . (Month, D | ay, Year) | Birthplace (State or Foreign Country) |
| | (a. sa | | Usual Residence of Decedent | | | | | Aug. 1 | 19, 1977 | / MD |
| | how | | 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits |
| | h the Marylan sr 28a-f show | cto | MD Anne Ar | undel | | Severn | a Park | | | 1 ☐ Yes 2 🔀 No |
| | vith th | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | What Country? |
| | a 23a | ra | 471 Yorkshire Dr | | | | 146 | | | USA |
| Maryland 21215-0036 | hours after death with the Maryland tural', or Itema 23a or 28a-f show al Examiner n ust be notified at | by Funeral | 11. Marital Status 1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates: | | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 XNo | ispanic Origin? (S in, Mexican, Puer Specify: | Specify Yes or Note 10 Rican, etc.) | o- 14. Ra Bla Speci | ace - American Indian, ack, White, etc. ify: White |
| 5-0 | 72 ho | Completed | 15. Decedent's Ed (Specify only highest gra | ucation de completed) | 16a. Dece | dent's Usual Occupa | ation | rkina | 16b. Kind of 8 | Business/Industry |
| 21 | ithin ne. | ig. | Elementary/Secondary (0-12) | College (1-4or 5+ | -) life. | kind of work done of DO NOT use retired | () | rkiirg | | |
| 12 | e filed within Hygiene. | 2 | 12 17. Father's Name (First, Middle, Last) | | | Sales | | | | tomobile Ind. |
| anc | d day |) Be | Philip A. Roussea | aux | | | 18. Mother's Nar | ^{me (First, Middle} Rosenda | | me) |
| 2 | d 2 should be ith and Mental Ith and Mental Ith and Ith Ith Ith Ith Ith Ith Ith Ith Ith Ith | ြ | 19a. Informant's Name/Relationship (| | 19b Maili | ng Address (Street a | | | | State Zin Code) |
| | 2 - A 2 - G | | Philip A. Roussea | • • • • • • • • • • • • • • • • • • • • | | Yorkshire | | | | |
| Baltimore, | es 1 and of Healt fitam 2 rother | | 20a. Method of Disposition | | | osition (Name of matory or other place | -1 | Date | | - City or Town, State |
| Ē | Page nent c ant: If | | 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | | | edral Ceme | etery N | ov. 8, 2005 | Baltim | more, MD |
| alt | permit. Pages Department of Important: If i any Injury or o | | 21. Signature of Funeral Service Licen | see // | B | Name and Address | | | | k Funeral Home |
| | 20 E 2 3 | | A homes K | Hlm | 7 | JJ GOV. K. | тссите п | wy, seve | erna Par | k, MD 21146 |
| | Physician | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition | olications that caused to one cause on each line | | ser the mode of dying | | | irrest, | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | u | consequence of): | 50110-1 | 0000 | 1000 | | |
| | | - | Sequentially list conditions, | b. — Chin to for as a | consequence of). | | | | | |
| | ited nsit | Examiner | Sequentially list conditions, if any, leading to in insediate cause. Enter Underlying Cause (Disease or injury | Dua to (or as a | consequence off. | | | | | |
| Ć. | rtificate be executed ng physician and sas the burial-transit | Exal | that initiated events resulting in death) Last | c. Due to (or as a | consequence of): | | | | | |
| 68760, | e be ysicia e bur | | | d. | | | | | | |
| 68 | rtifical ng ph | Medicai | | | | | | | | |
| .O. Box | The law requires that the death ce ste has been signed by the atlendir page 2 should be detached for use | Physician// | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□ Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | | | | ate of delivery onth Day Year |
| Q _ | signed b | by Pt | Part II. Other significant conditions co | entributing to death but | not resulting in the u | nderlying cause give | n in Part I. | 23e. Did t | obacco use con | tribute to the cause of death? |
| rds | w require: been sig should be | g p | | | | | | 10 | Yes 2 No | 3 Probably 4 Unknown |
| of Vital Records, | The law requisete has been page 2 should | Completed | | | | | | | osy ormed? | Were autopsy findings available prior to completion of cause of death? |
| ita | Ician: Th certificate rector, pag | Bec | 25. Was case referred to medical examiner? | ** | | - | 26. Place of Dea | th (Check only o | | 1⊠Yes 2□ No |
| Ž | hyelo his ce | Jo. | 157Yes 2□No | Hospital: 1 Inpatient | 2 ER/Outpatier | t 3 DOA Othe | - | ome 5 Resid | | ner (Specify) Scene |
| L C | ing P | ë. | 27. Manner of Death 1 □Natural 5 □ Pending | 28a. Date of Injury (Month, Day | Year) 28b. Time of Injury | 28c. Injury Work | | 28d. Describe I | now injury occur | |
| Sio | tend death tor: / the fi | cat | 2 Accident investigation 3 Suicide 6 Could not be | 11/4/6 | , , , , , , | P.M 10Y | es 25 No | SUBTE | | |
| Division | after of Direction by | Certification: | 4 Homicide determined | 28e. Place of Injunguilding, etc. | y - At home, farm, str (Specify) | eet, factory, office | | City or Tov | vn, State) | per or Rural Route Number. |
| | To the Hospital or Attending Physician: Ti within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa | edical C | 29a. Certifier 1 Certifying Phy (Check only one) | sician: To the best of | my knowledge, death xamination and/or inv | occurred at the time restigation, in my opi | e, date and place. | and due to the | cause(s) and ma | Of, GLEN BIRME, HI anner as stated. and due to the cause(s) |
| | To th within To th compl | Me | 29b. Signature and title of certifier | | | 29c. License | | | | d (Month, Day, Year) |
| | | | 1 aux | • | | O.C.M | F | 7 | \Torrom! | 05 2005 |
| | | 1 | 30. Name and address of person who o | ompleted cause of dea | th (Item 23a) (Type, | | • <u>C</u> I • | | wovember | 05, 2005 |
| | | | ANA RUBI | 0,40 | 111 Penn | Street | Raltimor | a Mary | land 212 | 001 |

State Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2005 37 Registrar's Signature

| | | | | 1- State of Maryland / Department of Health and I Certificate of Death | | 2005 38437 |
|---------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------|
| | | Physici | | 1. Decedent's Name (First, Middle, Last) William Walter Reeves, Jr. | 2. Date of Death Month NOV • 6 | Day Year 3. Time of Death 11:50a M |
| | | /Medio | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | 1 | 4c. County of Death |
| | | | | Charlotte Hall Veterans' Home Charlotte Hall 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | | St. Mary's |
| | | Funeral Director | | 578-22-8536 1√√ M 2□F 80 Yrs. Months Days Hours Min. | (Month, Dey, 1) 8/5/19 | |
| | | with the Maryland a or 28a-f show the mulfilled at | L | 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits |
| | | Ba-f | Director | MD Calvert Dunkirk | | 1 X Yes 2 ☐ No |
| | | with the | | 106. Street and Number 10f. Zip Code | 100 | . Citizen of What Country? |
| | | death y | Funeral | 6439 Meadowlark Drive 20754 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert | pecify Yes or No- | USA 14. Race - American Indian, |
| | 036 | is 1 and 2 should be illed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event. The Medical Explanation and be notified at | by | 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No | o Hican, etc.) | Black, White, etc. Specify: White |
| _ | Maryland 21215-0036 | 2 should be filled within 72 hours and Menial Hygiene. Is marked other than "natural", aumatic evant, Tre Wick of Exn | Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work if the DO NOT use ratified) | king | b. Kind of Business/Industry |
| 7 | 212 | d with giene. | mo | Elementary/Secondary (0-12) College (1-4or 5+) 12 Inspector | τ | J.S. Government |
| SOAN | pu | be file tal Hy d othe | Be | | ne (First, Middle, Ma | |
| 2 | ryla | hould d Men marke matic | 2 | William Walter Reeves, Sr. Edith. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru | Curry | Situat Town State Tin Code |
| | | 1 and 2 s Health an tam 27 is i | | Brett Reeves/Son 6439 Meadowlark Dr | | , , , , , , , , , , , , , , , , , , , , |
| - | Baltimore, | es 1 a of Hea fitam rothe | | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) | | c. Location - City or Town, State |
| 15 | ţ | Pag ment tant: I | | '4 □Donation 5 □Other (Specify) Chesapeake Crem. 11/ | 8/2005 B | eltsville, MD |
| 200 | Bal | permi. Pages 1 an Department of Heal Important: If itam 2 any injury or other once. | | 21. Signature of Funeral Service Lensee 22. Name and Address of Facility Ri PO Box 430, Duni | | ood F.H., P.A. |
| 4 | | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. | or respiratory arres | Approximate Interval Between Onset and Death |
| 7 | | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Land Suphie Hunt Follow Due to for a Consequence of): Sequentially list conditions. | | 3.133, 4.10 334.11 |
| 3 | 7 | Examiner | | Without V-right PIFI-ES | | |
| | | D H | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | |
| 3 | ó | ate be executed oblysician and the burial-transit | Examiner | that initiated events resulting in death) Last C. Due to as a consequence of): | | |
| 2 | 68760 | certificate be Iding physicia Ise as the bur | Physician/Medical | d. | | |
| , | ŏ | | an/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy | | 23d. Date of delivery |
| 5 | O. B | the death y the atter iched for u | ysici | in the past 12 months? 1 Yes 2 No 9 Unknown 1 Other (specify) | | Month Day Year |
| 2 | ď | w requires that the de been signed by the s should be detached | by Pr | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobac | co use contribute to the cause of death? |
| 3 | ords | requires een sign nould be | | Johnsy Arboy Dilly , Mimin | 1 🗆 Yes | 2 No 3 Probably 4 thinknown |
| a | Vital Records | 28 8 | Completed | | 24a. Was an autopsy performe | 24b. Were autopsy findings available prior to completion of cause of death? |
| 3 | alF | sician: The lav certificate has rector, page 2 | e Col | 25. Was case referred to medical 26. Place of Deal | 1 Yes 2€ | No 1 ☐ Yes 2 ☐ No |
| (| Ξ | Phyaician: this certific ral director, | 0 8 | examiner? | th <i>(Check only one)</i> ome 5 ☐ Residence | e 6 ☐Other (Specify) |
| 5 | n of | iing Phya J. After this funeral di | on: T | 27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? | 28d. Describe how | |
| 3 | Division | Attanding r death. sctor: After y the fune | icati | 2 Accident investigation M 1 Yes 2 No | ORI Leasting (Street | Acad Number of Device Number |
| DIlliam | Div | al or Attanos after death | Certification: | 4 Homicide determined building, etc. (Specify) | City or Town, S | t and Number or Rural Route Number, State) |
| 3 | | To the Hospital or Attanding Phyaician: The within 24 hours after death. To tha Funaral Director: After this certificate ha completely filled in by the funeral director, page | edical (| 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. | and due to the caus red at the time, date | e(s) and manner as stated. and place, and due to the cause(s) |
| | | To the within 2 To tha complete | Me | 29b. Signature and title of certifier 29c. License number | 29d. | Date signed (Month, Day, Year) |
| | • | | | DO0 61947 | | 1/7/5 |
| | • | 1+C | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manos Mathur, M.D. 110 Hospital Rd. #305 Prin | ce Frode | ariak MD 20679 |
| | | Sta | te | 31. Date filed (Month, Day, Year) 32. Registra/s Signature | ce trede | ELIUM, MID 20070 |
| | | Registr | ar | NOV 0 8 2005 Means to South | | |

DHMH 17 Rev 1/2001

| | | | State of Maryland / Department of Health and | | | 20120 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------|----------------------------------------------|
| | | | 1- State Registrar Certificate of Death | Reg | 4.002 | 38438 |
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Mary Elizabeth Ryan | 2. Date of Death Month November | Day Year | 3. Time of Death 9:00 A |
| 1 | Examin | a | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea | th | 4c. County of Dea | th |
| | Funeral Director | | Wilson Health Care at Asbury Village Gaithersburg 5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$ | | | omery thplace (State or Foreign ountry) York |
| | and w | | Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | • | | 10d. Inside City Limits |
| | Maryli f sho | tor | Maryland Montgomery Rockville | | | 1 ∰Yes 2 □ No |
| | n 28e | Director | 10e. Street and Number 10f. Zip Code | 10 | g. Citizen of What Co | ountry? |
| | 23a c | | 4 Monroe Street #305 20850 | | USA | |
| | er des | by Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (3 If Yes, specify Cuban, Mexican, Puel III) | Specify Yes or No- rto Rican, etc.) | 14. Race - Ame Black, Whit | |
| 36 | hours after death with the Maryland turel', or Items 23a or 28e-f show al Examiner must be notified at | by F | 1 Never Married 2 Married 1 | | Specify: | White |
| 2-0 | hin 72 hours after death with the Marylan s. an "neturel", or Items 23a or 28e-f show Medical Examinet must be notified at | Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo | orkina 10 | 6b. Kind of Business | |
| 121 | E 2 2 | mple | Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) | | | |
| d 2 | be filed with tal Hygiene of other the event, the | | 5+ Financial Manager 17. Father's Name (First, Middle, Last) 18. Mother's Na | me (First, Middle, Ma | eneral Ele aiden Sumame) | ectric |
| lan | | To Be | | Veronica | Carroll | |
| Maryland 21215-0036 | 2 shoul and Me Is mari | | 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Relationship</i>) | | | Zip Code) |
| | permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 Is marked any injury or other traumatic e ance. | | | lumbia, M | | 21044 |
| Baltimore, | Pages 1 | | 1 ☑Burial 2 ☐ Cremation 3 ☑Removal from State St. Alphonsus | | Oc. Location - City or | |
| İtin | artmer ortent injury | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | | \$2.5 | e,New York |
| Ba | permit. Departr Importe any inji | | Will Example Francis J. Collins 500 University Blv | Funeral : | Home, Inc | • • MD 20901 |
| | Vacable 1 | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause in each line. | c or respiratory arres | | Approximate Interval Between |
| T | Physician | | Immediate Cause (Final disease or condition Failure to Three | adrel | Et | Onset and Death |
| | /Medical Examiner | | Dye to (or as a consequence of): | . , | | |
| | | e | Sequentially list conditions, fi any, leading to immediate b. Due to (or as a consequence of): | | | |
| | od ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | |
| 0, | e be executed sician and s burial-transit | | resulting in death) Last Due to (or as a consequence of): | | | |
| 09289 | <u>~</u> ~ a | dicai | d | | | |
| Box 6 | The law requires that the death certificate tie has been signed by the attending phy age 2 should be detached for use as the | Physician/Med | IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy | | 23d. Date of de | livery |
| | e death | sicla | in the past 12 prontns? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) | | Month | Day Year |
| P.0 | that the de ed by the detached | | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did toba | acco use contribute lo | the cause of death? |
| Records, | uires t signe | d by | Radiation precessionitis, anemia | 1 | | robably 4 Unknown |
| COL | law requir as been si 2 should I | Completed | chronic Lisease. Adienal insufficien | 24a. Was an | 24b. Were at | utopsy findings available |
| Re | The la | mo | Diabetes II. Bladder caregionia | autopsy performe | | completion of cause of |
| Vital | icien: Th certificate rector, pag | Bec | eyaminer? | ath (Check only one) | | |
| of \ | Physicien: this certific ral director, | 2 | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing | Home 5 Residen | | city) |
| | ding After fune | tlon | 27. Mann of Death 28a. Date of Injury 28b. Time of Injury 2 Accident investigation 2 Accident investigation | 28d. Describe how | injury occurred | |
| Division | or Attending after death. Director: After in by the fune | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Stre City or Town, | et and Number or Ru | ural Route Number, |
| Ö | rs afte | Cert | building, etc. (Specify) | City di Town, | State) | |
| | To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at th | e, and due to the cau urred at the time, dat | ise(s) and manner as e and place, and due | s stated. e to the cause(s) |
| | To the within 2 To the comple | Σ | 29b. Signature and title of certifier 29c. License number | 290 | d. Date signed (Mont | h, Day, Year) |
| • | 12 | | 14 Frank prischhald. DO 4115 | Vo | verrber | 9,2005 |
| | 10 | | 30. Name and address of person who completed cause of death (Them 23a) (Type, Print) 26 / RUSSE 14. ROBERT BIRSCHBALL WID COAITHER | LL 4UZNO | nn 2 | 0877 |
| | Sta Registi | | 31. Date filed (Month, Day, Year) NOV 1 4 2005 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Riguelme State of Maryland / Department of Health and Mental Hygiene 05 - 7529Reg. No. 0 Certificate of Death AKG 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 8, 2005 **Physician** 1:29 A RTCHARD DAVID RIGUELME /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 12225 Old Gunpowder Road Beltsville If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 1986 Silver Spring, 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🕱 M 2 🗆 F 214, 27, 9674 19 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f ahow or then "natural", or iteme 23a or 28a-f ahov The Medical Examinar must be nutified at 1X Yes 2 □ No Director Prince George's Maryland Berwyn Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8412 57th Avenue 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after ☐ Yes 2 🔯 No f Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Apprentice Electrician Electricial Trade permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Marcella Dastoli David Riguelme 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8412 57th Avenue, Berwyn Heights, Maryland 20740 David Riguelme/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition injury or c 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Ceme. 11/12/2005 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, ND 20904 23a. Part1. Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the majories. List only one cause on each line. Approximate Interval Between Onset and Death Imm - e Cause (Final disease or condition INSVRIEC Physician MULTIPLE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a consequence of) Examiner taw requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1. Yes 2 □ No 24a. Was an certificete has page 2 1⊠Yes 2□No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) at SCENE Certification: To 1X Yes 2 □ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural To the Funeral Director: Aft
To the Funeral Director: Aft 5 Pending PASSENGER OF CAR IN COLLISION 1 Yes 2 No 1:16 A M investigation 8/05 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 4 Homicide 12225 old gunpavaler Rd, Bettsville, MD ROAD 29a. Certifier Medical 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) **Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. November 8, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) egistrar's Signates State 2005

Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12.11/05 TT State of Maryland / Department of Health and Mental Hygiene OF Juan Ramirez Reyes 05 - 75681 - For State Registrar AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month November 9, 2005 Juan 7:29 P M Reyes Ramirez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Chever 1 y
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) **Funeral** 1**₩**M 2□F Days Months Hours Director none Yrs. 56 May 24,1949 Mexico Usual Residence of Decedent the Maryland 10a. Sta MD 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at Prince George's Riverdale Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 5509 Taylor Road 20737 itema 23a Mexico death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If tem 27 ie marked other them. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Ves 2 No Specify: Mexican Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Asphalt Mechanic Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Enrique Reyes Elidia Ramirez 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agustin Santos Reyes/Nephew 5509 Taylor Road Riverdale, Md 20737 20b. Place of Disposition (Name of cemetery, crematory or other place)
Panteon Civil
San Nicolas Tolentino 20a. Method of Disposition 20c. Location - City or Town, State
Iztapalapa, Mexico 11/18/05 1 Burial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
PHILIP D.RINALDI FUNERAL SERVICE, P.A.
9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician chest miuries Head and /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Attending Physician: The law requires thet the death certificate be executed physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 🗌 No 1 V Yes 1 Y Yes 2 No 25. Was case referred to medicat examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No P this eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred passenger of motor vehicle 5 Pending investigation 1 Naturat death. 11-9-05 1 ☐ Yes 2 1 No Struck of fixed object

Struck of fixed object

Russian (Street and Number or Russi Route Number,
City or Town, State) out of 1000 and 202

St 17: Large (445) 7:00 2 Accident 6 ☐ Could not be 3 🗋 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Road within 24 hours e 29a. Certifier Medicai To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ho, O.C.M.E. November 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI LING MID 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) NOV 1 4 32 Registrar's Signature State 2005

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James 6:50 A M Paul Ray 2005 November 9 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Allegany Cumberland Sacred Heart Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March 27 1922 Social Security Number 5. Social Security Number 215–16–4699 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 100M 2□F Months Days 83 Yrs. Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 21 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, Ital Medical Examinations. 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County MD. Allegany Westernport 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 424 Hammond 21562 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

★CRYes 2 □ No WW 2
If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married XX Married white 1 ☐ Yes XXNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paper Manufacturer Machine Operator unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth James Ray Ray 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2, Box 354, Fort Ashby, West Virginia 26719 Robert Daigle/ step son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland, Maryland Cumberland Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee Mu 111 Church St., Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) acut 5 days /Medical Due to (or as a consequent of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (piecase of injury) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Cause (Disease of I that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 HAKnown been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 this certificate 1 ☐ Yes 2 NG Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a 29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21244 en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10701 NEW GEORGES CREEK RD. FROSTBURG, MD. 21532 DR JESUS TAN, 31. Date filed (Month, Day, Year) Registrar's Signature State 0 2005 Registrar

| | | | 1 - For State Registrar | State of Ma | aryland / | | artmeni rtificate | | | and Me | | giene Reg. No | 11115 | 381 | +42 |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------|-------------------------|---------------------------------------|--------------------------|--------------------------------------|-----------------------------|----------------------------|----------------------|--------------------------------------------|----------------------------------|-----------------------------|
| 91 | Physici | | 1. Decedent's Name (First, Middle ACSON | LEE | Ros | + | | | | 2 | Date of De Month | Da | y Year | | e of Death |
| | /Medi Examir | | 4a. Fecility Name (If not institution | , give street and number) | - | | 4b. City, | Town, or i | ocation of | f Death | OVEVED | | . County of De | ath | |
| | | | Shady Grove Adv | entist Hosp: | ita1 | | Rock | vill | e | | | Mo | ontgome | ry | |
| *** | Funeral | | 5. Social Security Number | 6. Sex 7. Age | e (In yrs. last | | If Under Months | | If Under 2 Hours | 24 Hrs. 8 Min. | Date of Bir (Month, Da | | | | te or Foreign |
| | Director | | 496–46–9623 Usual Residence of Decedent | | 61 | Yrs. | | | | Jı | une 26 | , 19 | | ssouri | |
| | a-f ahov | ctor | 10a. State 10b. County Maryland Montgo | omery | German | | | | | | | | | | e City Limits ∕es 2 XNo |
| | or 28 | Dire | 10e. Street and Number | | | | 10f. Zip | | | | | 10g. Ci | tizen of What C | ountry? | |
| | s 23s | rai | 13099 Open Hear | | | | 2087 | | | | | USA | | | |
| 21215-0036 | 72 hours after death with the Maryland natural', or Itama 23a or 28a-1 ahow lites Exac ilirar ivust be notilled at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced | 12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:] | 10 | | Was Deced f Yes, spec 1 ☐ Yes 2 | | panic Orig , Mexican, Specity: | gin? (Specr , Puerto Ric | fy Yes or No can, etc.) |)- | 14. Race - Am Black, Wh Specify: Wh: | ite, etc. | 1, |
| 9 | 72 hours natural', | ted | 15. Decedent | 's Education | | 6a. Dece | dent's Usua | l Occupat | ion | - (1 | | 16b. K | ind of Business | | |
| 21 | - 3 | Completed | (Specify only highes Elementary/Secondary (0-12) | College (1-4or 5 | +) | life. | kind of wor DO NOT us | k done du e retired) | iring most | of working | | | | | |
| 12 | be filed within 72 ho ital Hygiene. id other than "natur evant, the Maxical | | 47 Falls of Name (Class Middle) | 2 | Pι | ırcha | sing | | | | | | ctronic | s Comp | any |
| Maryland | 2 should be filled within and Mental Hygiene. Is marked other than eumatic event, the M | To Be | 17. Father's Name (First, Middle, I Clarence Edwin | | | | | 1 | | | First, Middle, arriot | | Sumame) | | |
| lary | s 1 and 2 should f Health and Men Item 27 Is marke other treumatic | - | 19a. Informant's Name/Relationsh | | 1 | 9b. Mailir | ng Address | (Street ar | d Number | r or Rural F | Route Numbe | er, City o | or Town, State, | Zip Code) | |
| | if Health Item 27 other tr | | Shirley A. Root | /wife | | | | | | | - may | | MD 208 | | |
| nore | 0 0 | | 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation | | 20b. Place | | sition (Nam natory or ot te Cre | | | Novemb 10, 20 | | | ocation - City or | | • |
| Baltimore, | permit. Pag Department Important: I any injury o | | 4 □ Donation 5 □ Other (Sci 21. Signature of Funeral Service I | | Chesa | - | | | | | | | P.O. Bo | | |
| ш | 20189 | | Devely LA | telto | MO125 | 1 Be | verly | T | Heckr | otte. | P.A. | C1 a | rksvil | le, MD | |
| | Physician /Medical | | 23a. Part1. Enter the disease, or shock, or heart failure. List disease or condition resulting in death) | complications that caused only one cause on each lin a | 1 Au | rev | or the mode $> 5\tilde{c}$ | | | ardiac or r | espiratory ar | rrest, | | Approxir Interval Onset ar | mate Between nd Death |
| | Examiner | | Sequentially list conditions | b. | a consequent | . 0 01). | | | | | | | | | |
| | ted nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | ร ซึบทริงตับสกับ | ia of). | | | | | | | | | |
| o, | be executed sician and burial-transit | | that initiated events resulting in death) Last | c. Due to (or as a | a consequenc | e of): | | | | | | | | | |
| 8760, | physici the bu | edical | | d | | _ | | | | | | | | | |
| 9 x | n certific anding p | /Me | IF FEMALE: | 23c. If yes, outcome of | of pregnancy | | | | | | | | 004 0-444- | 15 | |
| O. Box | requires that the death certificate be executed een signed by the ettending physician and nould be detached for use as the burial-transit | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 🗌 Fetal dea | | Ectopic pre Other (spe | | | | | | 23d. Date of de Month | Day | Year |
| rds, P. | w requires that been signed I should be det | by | Part II. Other significant condition | . 1. | it not resulting | g in the ur | nderlying ca | use given | in Part I. | | | obacco u Yes 2 | ise contribute to | the cause of | _ |
| Division of Vital Records, | Fhe law te has b age 2 sl | Completed | Perpheral | VASCUla | di | 500 | osi | | | | 24a. Was autop perfo | | 24b. Were a prior to death? | completion o | gs available of cause of |
| ita | tu ta | BeC | 25. Was case referred to medical examiner? | 3 | | | | | 26. Place | of Death (C | 1 ☐ Yes Check only o | | 1 L Yes | 2 □ No | |
|) V | Physician: r this certific ral director, | 10 | 1 ☐ Yes 2 ₹ No | Hospital: 1 thipatier | | Outpatien | 3 DO | Other: | 4 🗌 Nurs | sing Home | 5 Resid | dence (| 6 □Other (Spe | icify) | |
| o uc | ding P | ion: | 27. Manner of Death 1 ☐ Statural 5 ☐ Pending | | Year) 28b | . Time of Injury | | lc. Injury a Work? | | | d. Describe h | now injur | y occurred | | |
| visio | l or Attending after death. Director: Afte in by the fune | ificat | 2 Accident investig. 3 Suicide 6 Could n | ot be 28e. Place of Inju | ry - At home, | farm, stre | M eet, factory, | | s 2 N | | | | d Number or R | ural Route N | umber, |
| ă | in Diffe | Certification: | 4 Nothicke | building, etc | . (Specify) | | | | | | City or Tow | vn, State |) | | |
| | To the Hospitel within 24 hours a To the Funeral Completely filled | edical | 29a. Certifier (Check only one) | Physicien: To the best of xaminer. On the basis of and manner stat | examination a | ge, death anovor inv | occurred a estigation, | t the time in my opir | , date and non, death | place, and occurred | due to the dat the time, d | cause(s) date and | and manner as place, and due | s stated. to the cause | e(s) |
| | Nithin Fo the | Me | 29b. Signature and title of certifier | | - | | 29c. | License r | number | | | 29d. Dat | e signed (Mont | h, Day, Year | ·) |
|) | | | 100ch | A BOUN | 10 | | D | 5-3 | 317 | 7 | 1 | 404 | ember | 820 | 205 |
| 0 19 | <i>></i> | | 30. Name and address of person v | who completed cause of de | ath (Item 23a | ı) (Type, I | Print) | 100 | W | D.W. + | Lan | - | embou There | 20 | 877 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Pogistra | r's Signature | | 1 | | Chr | W. W. | 1.3 | 101 | + Theks | ouig HI | 0 |
| 14 | Registr | ar. | MUV I O | 2005 | as St. | Die Control | real! | | | | | | | | |

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number **Funeral** 194 03 7225 Director Usuat Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland 10a. State mportant: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at MD **Funeral Directon** 10e. Street and Number 891 Dorsey Hotel Rd. 11. Marital Status Baltimore, Maryland 21215-0020 ۾ Be Completed permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner To the Funerel Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer Nementia δ Completed within 24 hours efter death.

To the Funerel Director: After this certificate Be 25. Was case referred to medical examiner? Certification: To 27. Manner of Death Medical 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mas CONPORATE DR, GRANTSVILLE, MD 21536 31. Date filed (Month, Day, Year) 32. Registar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygien [For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** obinsor HODREW :30 AM 05 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner County of Death Pr heaton MG are ont Gomes If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Month, Day 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 30161 1**X**M 2□ F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show th and Mental Hygiene. ?? Is marked other then "natural", or Items 23a or 28a-1 shov traumatic svent, the Medical Examinar must be notified at Completed by Funeral Director 1 Yes 2 No 10nt60mer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TINC 3nKTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Inoma 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) l remattery 21. Signature of Funeral S 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed iding physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery been signed by the atter should be detached for u 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2□ No 1 ☐ Yes 212 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours effer death.
To the Funeral Director: Affer thi
completely filled in by the funeral to 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the dauso(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52261 30. Name and address of person who completed ath (Item 23a) (Type, Print) iEorgia Que, S.S. MD. 21910 Hlan a 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar S 2005

State of Maryland / Department of Health and Mental Hygiene 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Anne Elizabeth Simmons 10 pm 2005 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Goodwill Mennonite Home Grantsville Garrett If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🕢 F Yrs. 219-16-0090 Director May 15, 1924 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at MD Garrett Grantsville 1 ☐ Yes 2 No Director 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? 88 Killdeer Lane 21536 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 'natural', or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖫 No Specify: white Specify: ξ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Transcriber Medical Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Sears Ella Mae Kane ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tr Waynard L. Simmons/husband 88 Killdeer Lane, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Country Side Crem. Nov. 15, 2005 Davidsville, PA 21. Signature of Funeral Service Licensee Newman FuneraTillHomes, P.A., PO Box 275 una 179 Miller St., Grantsville, MD 23a. Part1. Erter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner e Congestive heart failure Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, more Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? funeral director, Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🗙 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident s after decrei rel Director: Afte 5 Pending investigation 1 Tes 2 No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 11-14-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 124 Miller St., Grantsville, MD 21536 Robin Bissell, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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2005

| | | | 1 - For State Registrar | State o | of Maryla | and / Dep <i>Ce</i> | artment <i>rtificate</i> | of He | alth an <i>eath</i> | d Menta | | jieme | 05 | 384 | 46 |
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| | | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | te of Dea | th | | 3. Time | of Death |
| | Physic /Medi | | Charles Rober | t Shelt | on, I | II | | | | | onth rembe: | r 3, 2 | 2005 | 11:4 | 1 A.M |
| | Exami | | 4a. Facility Name (If not institution, | give street and nu | mber) | | 4b. City, To | own, or L | ocation of E | Death | | | nty of Deat | | |
| | | | Calvert Memoria | l Hospita | ıl | | Princ | ce Fi | rederi | lck | | Cal | vert | | |
| | Funeral | | | 6. Sex 1 X IM 2□ F | | rs. last birthday) | | Year Days | Hours N | | te of Birth | Year | 9. Bin | thplace (State | or Foreign |
| | Director | | 577-28-9160 | 1251 M 2 L P | 87 | Yrs. | | -,- | | Ju | ne 8, | 1918 | Wash | ington | DC |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. | City, Town or Lo | ncation | | | | | | - | 10d Inside (| Dib. Limite |
| | /anyi | ō | M3 3 3 | | | | | | | | | | | 10d. Inside (| S X□No |
| | r 28a-f show | Director | Maryland Calvert | | Sc | olomons | 10f. Zip C | 'odo | | | 1 | O= Cities- | 4 140 - 4 0 | | |
| | ₹ 0 H | ā | 11450 Asbury Cir | cale Ant | #215 | | 2068 | | | | | 0g. Citizen o | | - | |
| | ns 23a | era | 11. Marital Status | 12. Was Dec | | | | | anic Origin | 2 (Specify V | | Inited | | rican Indian, | |
| (0 | riter | Funerai | 1 Never Married 2 Marrie | Armed Fo | orces? | 0.0. | Was Decede | y Cuban, | Mexican, P | uerto Rican, | etc.) | В | lack, Whit | e, etc. | |
| 030 | hours after o tural', or Iter | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Gir Year or D | ve | I | 1 ☐ Yes 2 | No - | Specify: | | | Spec | cify: Wh | ite | |
| 21215-0036 | "natural", | Completed | 15. Decedent's | Education | | 16a. Dece | dent's Usual | Occupation | on . , | | | 16b. Kind of | | | |
| 21 | within 7 ene. than "r | pie | (Specify only highest Elementary/Secondary (0-12) | College (| 1-4or 5+) | life. | kind of work DO NOT use | done dur retired) | ring most of | working | | | | , | |
| | | 201 | | 5+ | | Denti | st | | | | | Denti: | stry | | |
| p | al Hy al Hy a oth | Be (| 17. Father's Name (First, Middle, L. | | | | | 18 | B. Mother's | Name (First, | Middle, A | Aaiden Sum | ame) | | |
| <u>yla</u> | Ment Ment Brkac | 2 | Charles Robert S | Shelton, | Jr. | | | | Edith | Heis] | ley | | | | |
| Maryland | s 1 and 2 should be filed f Health and Mental Hyg itam 27 is markad otha other traumatic event, | | 19a. Informant's Name/Relationshi | | | | ng Address (| | | | | | | | |
| 2 | 1 and 1 Health tam 27 other tra | | Mary E. Shelton | (Daughte | | | | | rcle, | Apt. | #315 | , Solo | omons | , MD 2 | 0688 |
| Baltimore, | permit. Pages 1 am Department of Heali Important: If itam 2 any injury or other once. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation : | Bemoval from | | . Place of Dispo cemetery, crei | sition (Name natory or othe | of er place) | | Date | 2 | 20c. Location | n - City or | Town, State | |
| Ē | Pag ment ant: ury c | | `4 □ Donation 5 □ Other (Spe | ecity) | Me | tropoli | tan Cr | emat | ory 1 | 1/09/0 |)5 A | lexan | dria, | Virgi | nia |
| alt | Depart Depart Import any inj once. | | 21. Signature of Funeral Service Li | censee | | | 2. Name and | | | | | | | | |
| ш | 20 E 29 | | 1 3t 5.5 | itt | | | | | | | | | , Mary | land 206 | 576 |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or canock, or heart failure. List of mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a. Co | ronary (or as a conse | Artery equence of): | | | such as can | uiac or respii | atory arre | st, | | Approxima Interval Be Onset and | tween |
| 68760, | ficate be executed physician and sthe burial-transit | edicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | or as a conse | | | | | | | | | | |
| O. Box | death certi e attending d for use a | Physician/Mec | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | irth 2 Fe ant at time of | tal death 3 | Ectopic preg Other (spec | | | | | | ate of deli | - | Year |
| of Vital Records, P. | Se Log | by | Part II. Other significant condition Congestive heart | s contributing to de | eath but not re | sulting in the ur | nderlying cau | se given i | n Part I. | 23 | e. Did toba | | | the cause of o | |
| Ö | w requir been si should | Completed | | | | | | | | _ | 146 | | | | |
| Be | | d L | | | | | | | | - 24 | a. Was an autopsy | | prior to co death? | opsy findings ompletion of c | available ause of |
| Ø | | | OF West and a few days at the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second | | | | | | | | perform Yes 2 | | 1 🗆 Yes | 2□ No | |
| Ξ | | Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | | v | | | | Death (Checi | | | | | |
| | 를 하는 글 | 5 | 27. Manner of Death | 28a. Date | | ER/Outpatren 28b. Time of | | Injuny at | 4 Nursing | g Home 5[| Resider | nce 6 ⊡Oi winjuryoccu | ther (Spec | ify) | |
| on | ding Ph h. After th funeral | tion | Natural 5 ☐ Pending investiga | (Mont | h, Day Year) | Injury | M | Injury at Work? | 2 □ No | 200. 00 | SCHOO HOV | w mjury occu | med | | |
| Division | r Attending er death. rector: After by the fune | Certification; | 3 Suicide 6 Could no | t be | of Injury - At | home, farm, stre | | | 20110 | 28f Loc | ation (Str | not and Num | ther or Pu | al Route Num | har |
| Θ | after after Dire | erti | 4 Homicide determin | ed buildir | ng, etc. (Spec | cify) | set, ractory, o | IIIC o | | City | or Town, | State) | iber or Hui | a <i>i Houte Ivum</i> | Der, |
| | To the Hospital or Attent within 24 hours after death To tha Funaral Director: completely filled in by the | Medical C | 29a. Certifying (Check only one) 2 Medical Ex | Physician: To the aminer: On the ba | asis of examir | nowledge, death nation and/or inv | occurred at t | the time, my opini | date and pla on, death o | ace, and due | to the cau | use(s) and m | nanner as : , and due ! | stated. to the cause(s |) |
| | o thi o this omply | Me | 29b. Signature and title of certifier | A 7 | | 9.00 | 29c. L | icense nu | umber | | 29 | d. Date sign | ed (Month | Day, Year | |
| | - s - ō | | V. O.L. | Boots | 111 | no | DO | 0522 | 12 | | | | , | | |
| _ | | - | 30. Name and address of person wh | o completed cour | e of death /li- | am 23a) /Tune | | UJZZ | 44 | | INC | ovembe | £ 4, | 2005 | |
| 15 | +1 | | J. John Barth, I | | | | | ıite | 310 | Prince | s Fro | deri d | և ռոր | 20670 | |
| | Sta | _ | 31. Date filed (Month, Day, Year) | | egistra/s Sigr | nature | | | 510, | * * * * I I C | ⊃ rr∈ | CELTC. | N, MIL | 20078 | |
| | Registr | | NOV | 1 0 2005 | Head | do | Land | 2 8 | | | | | | | |

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| | | | 1 - For State Registrar | State of M | aryland | | artment rtificate | | | d Mental F | | 71115 | 38447 |
|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------|-------------------------------|---------------------------------|--------------------|----------------------------------|--------------------------------------------|----------------------------|------------------------------------------|-----------------------------------------------|
| | | á, | Decedent's Name (First, Middle, Last |) | | | tincate | OI L | Jeani | 2. Date of | Reg. N Death | lot: 0 0 0 | 3. Time of Death |
| | Physici /Medi | | SAMUEL | | | | SM | OLKI | ГN | Month NOVEM | | Year 2005 | 7:45 P |
| | Examir | | 4a. Facility Name (If not institution, give | street and number) | | | | | Location of D | | | c. County of Deat | |
| | | | 10706 ST. MARGARE | | | | 1 | SILV | ER SPI | | | MON | TGOMERY |
| | Funeral Director | | 5. Social Security Number 6. Se 128-03-8100 | x 7.Ag XIM 2□F | je (In yrs. la 90 | as <i>t birthday)</i> Yrs. | If Under 1 Months | Year Days | Hours N | | Day, Year | r) Co | hplace (State or Foreign untry) RAEL |
| | and ** | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | , Town or Lo | cation | | | | | | |
| | Marylan I show | Į. | | EDW | ,, | , | | | | | | | 10d. Inside City Limits 1 Yes 2 No |
| | r 28a | Director | MARYLAND MONTGOM 10e. Street and Number | LKI | | | 10f. Zip C | | ER SPRI | LNG | 10a. C | itizen of What Co | |
| | th wit | | 10706 ST. MARGARE | IS WAY | | | | 2 | 20902 | | | U.S. | Α. |
| | ams erms | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | Ever in U.S | 3. 13. | Vas Deceder | | | ? (Specify Yes or uerto Rican, etc.) | No- | 14. Race - Ame | rican Indian, |
| 36 | s afte | by Fu | 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 🔀 i | | | 1 ☐ Yes 25 | | | 20110 (110211, 010.) | | Black, White Specify: WH | |
| 9 | tural | | 15. Decedent's Edu | Year or Dates: | | 16a Decer | dent's Usual (| Jaguna | tion | | 105 | | |
| 212 | within 72 hours after death with the Maryland ane "natural", or Itams 23a or 28a-1 show than "natural", or Itams 25a or 28a-1 show ha Medical Exar. it ar mast be notified at | plet | (Specify only highest grad Elementary/Secondary (0-12) | e completed) | = 1) | (Give | kind of work OO NOT use | done di | uring most of | working | 160.1 | Kind of Business/I | industry |
| 21 | e filed within il Hygiene. other then " vent, the Me | Completed | Lighteniary/Secondary (0-12) | College (1-4or 5 | 3+) | | OPT | ГІСІ | AN | | | OPTICAL | |
| nd | be filed within 72 hours after death with the Maryla ital Hygiene. od other than "natural", or Itams 23s or 28s-1 show evant, the Medical Exer. it extress be notified at | Be | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mother's | Name (First, Midd | lle, Maide | | |
| yla | 2 should be and Mental Is marked c | 7 | TZVI SMOLKIN | | | | | | | L FREEDE | | | |
| , Maryland 21215-0036 | 7472 | | 19a. Informant's Name/Relationship (T) SYLVIA D. SMOLKIN | | | | | | | | | or Town, State, Z. SPRING, | |
| Baltimore, | permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other ONCE. | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F | Removal from State | cer | ace of Dispo metery, cren | sition (Name natory or othe | of er place |) | Date | 20c. L | ocation - City or 1 | Town, State |
| Ħ | artmer artmer ortant injury | 1 | ' 4 Donation 5 Other (Specify) 21. Signakir 1 weral Servi Licen | 90 | MT. | LEBAN | ON CEM | IETE | RY 11/ | 10/2005 | ADE | LPHI, MA | RYLAND |
| Ba | permit Depar Impor any in once. | | A ANTEN | 7 | | 1 | ANZANS | KY- | GOLDBE | RG MEMOR | IAL | CHAPELS, | INC. |
| ı | ¥ | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | ications that caused | the death. | Do not ente | er the mode of | of dying, | such as card | diac or respiratory | arrest, | LE, MARY | LAND 20852 Approximate |
| | Physician | | Immediate Cause (Final disease or condition | ALZHEIM | | TCFAC | F | | | | | | Interval 8 etween Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as | | | ш | | | | | | |
| | - Adminion | 7 | | Due to (or as | 2 CONSEQUE | ance of): | | | | | | | |
| | uted d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 240 (0) 43 | a consoque | 31100 017. | | | | | | | |
| ó | The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Еха | that initiated events resulting in death) Last | Due to (or as | a conseque | ence of): | | | | | | | |
| 8760, | ate be hysici the bu | dlcal | | 1. | | | | | | | | | |
| 9 | ding p | /Mec | IF FEMALE: | 20 If you systems | 06 | | | | | | | | |
| Вох | leath certific attending p | by Physiclan/Me | in the past 12 months? | 3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at | 2 Fetal d | death 3 | Ectopic pregr Other (speci | | | | | 23d. Date of deliv Month | rery Day Year |
| o. | the de | hysi | 1 | 9□ Unknown | timo or dea | .ui | Other (speci | ·y) | | | | | |
| S, D | res that iigned t be det | y P | Part II. Other significant conditions cor | tributing to death bu | ut not result | ting in the un | derlying caus | se given | in Part I. | 23e. Did | tobacco | use contribute to t | the cause of death? |
| ord | w require been sig | | | | | | | | | _ 1 | Yes 2 | XNo 3 □ Pro | bably 4 □Unknown |
| Record | e law r has be ge 2 sh | Completed | | | | | | | | 24a. Wa | opsy | 24b. Were auto | opsy findings available ompletion of cause of |
| | | | | | | | | | | per 1 ☐ Yes | fórmed? 2 <u>K</u>) No | death? | 2 □ No |
| Viital | | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2X No | lospital: | | | | | | eath (Check only | | | |
| o | g Phys er this eral di | - 1 | 27. Manner of Death | 1 Inpatie | v 2 | R/Outpatient 8b. Time of | | Injury a | 4 □ Nursing at | Home 5 XRes 28d. Describe | | 6 Other (Special | fy) |
| ion | death. ctor: After ty the funera | atlo | 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | / Year) | Injury | М | | s 2 No | | · | , | |
| Division of | or Attending after death. Director: After in by the funer | ertification; | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Inju- building, etc | ury - At hom c. (Specify) | ie, farm, stre | et, factory, of | ffice | | 28f. Location City or To | (Street an | nd Number or Rura | al Route Number, |
| | spital cours al cours al paral D | 0 | 200- C-15 200- | 1/4 | | | | | | | | | |
| | To the Hospital or Attentwithin 24 hours after death To tha Funaral Director: completely filled in by the | Medical | 29a. Certifier Check only one) Certifying Physical Examination | ner: On the basis of and manner sta | examinatio | edge, death on and/or inv | occurred at t estigation, in | he time my opir | , date and pla nion, death oc | ice, and due to the ccurred at the time | e cause(s) , date and |) and manner as s d place, and due to | stated. the cause(s) |
| | To t Com | Σ | 29b. Signature and title of certifier | / // | 1 | | | cense r | number | | 29d. Da | te signed (Month, | Day, Year) |
| | | | 1 DRIKE | pelle | ~ | | D09 | 834 | | | NOVE | EMBER 9, | 2005 |
| | 12 | | 30. Name and address of person who co | | | | | | | | | | |
| | Star | 6 | BARRY N. ROSENBAUM 31. Date filed (Month, Day, Year) | 32 Flagietra | r'e Signatur | ro | | UT A | AVE, KI | ENSINGTON | , MD | 20895-2 | 110 |
| | Registra | | NOV 142 | 005 | w L | K A | rack | | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. . Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 11, **Physician** HILDA IRENE SMITH 2005 2220 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOMEWOOD AT WILLIAMSPORT WILLIAMSPORT WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | MAR. | 2, 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2√2 F 214-34-0727 89 MARYLAND Director Vrs Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 28e-f ahow 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at Director MARYLAND 1 ☐ Yes 2√2 No WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 OLD NATIONAL PIKE 21713 Itams 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò þ 1 ☐ Yes 2 ☑ No Specify: 3 XWidowed 4 □ Divorced Specify. "natural" WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If itam 27 Is marked other than College (1-4or 5+) 12 CUTTING DEPARTMENT COAT MANUFACTURER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OSCAR HOUPT BEATRICE MAE FAULDERS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONNIE L. MILBURN, DAUGHTER 20027 LAPPANS ROAD, BOONSBORO, MD itam 2 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State

1 1 Donation 5 □ Other (Specify) = 5 Department of Important: If any injury or once. BOONSBORO CEMETERY 11/15/2005 BOONSBORO, MARYLAND 21. Signature of Funeral Service Lansee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713 Zimmerman BAST FUNERAL HOME 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician CPS18 disease or condition resulting in death) Wax /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physiclan/Medical Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the l IF FEMALE: for use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 2 Fetal death Day 4□Pregnant at time of death Month Year 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 **X** No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed MERKALOLULA 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2/ No Other: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. investigation 1 TYes 2 TNo filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funaral D 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha 29b. Signaty 29c. License number 29d. Date signed (Mgnth, Day, Year) 1)((1) (necru npleted cause of death (Item 23a) (Type, Print

State

Registrar

32. Registrar's Signature

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - State AVENDIFIC, perME Registrar | | PS,MCCO C | ertificate of | Death | | Reg. No. | 05 | 38449 |
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| Ph | ysici | an | Decedent's Name (First, Middle, Last | | . . | | | 2. Date of De Month | ath Day | Year | 3. Time of Death |
| , 5 / | Medic | al | Henry Lawr | | 11ey | | | Novemb | er 6, 2 | .005 | 9:14 a. ™ |
| E | kamin | er | 4a. Facility Name (If not institution, given 10400 Good Luck F | | | 4b. City, Town, o | | Death | 4c. Count | y of Death and | Prince George's |
| | eral ector | | 5. Social Security Number 6. S 231-96-7219 | 9x 7. Age IM 2□ F | (In yrs. last birthda 40 Yrs. | y) If Under 1 Year Months Days | | Hrs. 8. Date of Bir Min. July 2, | th 1965 | 9. Birthp Coun V1 | lace (State or Foreign try) rginia |
| aryland | idal | 7 | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or | | | | | | Od. Inside City Limits |
| the M | ctiffe | Director | D. C. NO | NE | Wash | ington | | | | | 1 Yes 2 No |
| ath with | ustber | ral Dir | 158 12th Street, | SE | | | 0003 | | 10g. Citizen of | What Coun | try? |
| Dattilliofe, IMaryiailla Z.I.Z.13-UU30 permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ehow | Examiner | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Endemed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | ver in U.S. 13 | I. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No | lispanic Origir an, Mexican, F Specity: | n? (Specify Yes or No Puerto Rican, etc.) | | ce-Americ ick, White, i ^{fy:} Whi | etc. |
| 72 hg | dical | etec | 15. Decedent's Ed (Specify only highest gra | ucation de completed) | 16a. Dec | edent's Usual Occup | ation | f working | 16b. Kind of B | Business/Ind | lustry |
| within the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the tra | e Mo | Completed | Elementary/Secondary (0-12) | College (1-4or 5+ | life. | DO NOT use retired tems Engin | d) | r working | m - 1 | 4 | . |
| filed v Hygie | int, | e Co | 17. Father's Name (First, Middle, Last) | 4 | sys | tems Engl | | Name (First, Middle, | | | Industry |
| y carlo | natic eve | To Be | T. Raysor Salle | | | | Sop | phie Anne | Re1son | | |
| and 2 sh ealth and n 27 is m | ner traum | | 19a. Informant's Name/Relationship (7 Lori T. Salley/ | * * * * | 158 | 12th St. | ,SE., V | or Rural Route Number Nashington | | | Code) |
| Dartilliore ermit. Pages 1 Department of H mportant: If item | ury or oth | | 20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | position (Name of ematory or other place itan Crema | | lov.8, 2005 | 20c. Location | | |
| permit. Depart | eny in | | 21. Signature of Funeral Service Licen | De 1/20 | 2 | 22. Name and Addres | ss of Facility | DeVol Fun ve.,NW.,Wa | eral Ho | me | |
| Pul | , | | 23a. Part) Enter the disease, or composition, or heart failure. List only of | ine cause on each line | he death. Do not er | nter the mode of dyin | g, such as ca | rdiac or respiratory ar | | | Approximate Interval Between Onset and Death |
| Physic /Med Exami | ical | | disease or condition resulting in death) | a. Due to (or as a | Consequence of): | HUTSUN. | Wanc | | - | | |
| Pa | sit | lner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Jue to (or as a | consequence of). | | | | | | |
| ertificate be executed ling physician and | | ŭ | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | consequence of): | | | | | | |
| tificate b g physic | as the b | Medical | | d | | | | | | | = |
| The law requires that the death certific at the law requires that the death certific at the law reducing p | | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at tir 9 □ Unknown | Fetal death 3 | □Ectopic pregnancy □ Other (specify) | _ | | | te of deliver onth [| y Day Year |
| quires that | 90 | þ | Part II. Other significant conditions co | ntributing to death but | not resulting in the | underlying cause give | en in Part I. | 23e. Did to | | | cause of death? |
| | page 2 should | Completed | | | | | | 24a. Was a autop: perfor | med? | prior to com death? | sy findings available pletion of cause of |
| cian: ertific | ŏ | | 25. Was case referred to medical examiner? | | | | 26. Place of | Death Check only or | | yes 100 Z | . L. No |
| Physi | <u> </u> | 2 | 1X Yes 2 No 27. Manner of Death | lospital: | 2 ER/Outpatie | | 4 LI INUI SI | ng Home 5 Resid | | | At scene |
| Attending Physician: r death. actor: After this certific | funeral | Certification: | 1 ☐Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Y | | Work | | 28d. Describe hi | | | |
| l or Atten after deat Director: | y the | lica | 2 Accident investigation 3 Suicide 6 Could not be determined | 28e. Place of Injury | 9:14 - At home, farm, st | * 1 | res 2 ⊠No | SUBJE(| T SHOT S | AF | Double Alian h |
| - 2 - | | i i | 4 ^r Homicide determined | building, etc. | (Specify) | | | City or Town | | ال المالي | Route Number, LGICV. NV PC |
| To the Hospital or within 24 hours af To the Funeral D | | edicai | 29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami | sician: To the best of a ner: On the basis of ea and manner state | my knowledge, dear | th occurred at the tim | e, date and plainion, death o | lace, and due to the coccurred at the time, d | ause(s) and ma ate and place, a | nner as stated | ted. he cause(s) |
| To th within To th | dimoo | | 29b. Signature and title of certifier | 1 11 | | 29c. License OCM | | | 9d. Date signed Novembe | | |
| 8 | | | 30. Name and address of person who co | - | th (Item 23a) (Type, | Print) 111 P | enn St | | | | and 21201 |
| 432 | Stat | | JA(K. M. Tith 31. Date filed (Month, Day, Year) | / (1) 32. Registrar's | Signature | | | | | - | |
| Reg | gistra | - | NOV 0 9 2 | 2005 | J H A | frank | | | | | |

| | | | 1 - State Registrar | | partment of Health and N ertificate of Death | Mental Hygien | 000 00400 |
|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | Parl Control | | 2. Date of Death | 3. Time of Death |
| _ | Phys /Me | ician dical | Flord | Sampso | n | November | 7 2005 2150 M |
| | 1 | niner | 4a. Facility Name (If not institution, give stre | et and number) | 4b. City, Town, or Location of Death | | 4c. County of Death |
| | | | THE MEMORIAC 5. Social Security Number 6. Sex/ | | U If Under 1 Year If Under 24 Hrs. | 10.0 | TALBOT |
| | Funer Directo | | | 2 F 7. Age (In yrs. last birthda | Months Days Hours Min. | 8. Date of Birth (Month, Day, Yea NOV, 26, 1 | 9. Birthplace (State or Foreign Country) 1927 Mary Land |
| | yland | Š | 10a. State 10b. County | 10c. City, Town or | Location | | 10d. Inside City Limits |
| | a-f st | ctor | Maryland TAlbo | + EAST | TON | | 1 AYes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | 10f. Zip Code | 10g. C | Citizen of What Country? |
| | s 23e | raf | 115 TAlbot Y | illage | 21601 | | USA |
| | ter de | Funeral | | Was Decement Ever in U.S. Armed Forces? | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | ecity Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| | O36 ours a | þ | 3 ☐ Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☐ No Specify: | | Specify: Black |
| dy | Ind 21215-0036 be filed within 72 hours after death with the Maryland and Hygiene. d other then "natural", or items 23e or 28e-f show event, the Medical Evantimar must be notified at | Completed | 15. Decedent's Educati (Specify only highest grade of | ompleted) (Giv | cedent's Usual Occupation ve kind of work done during most of work | | Kind of Business/Industry |
| 77: | 121 within | m d | Elementary/Secondary (0-12) | | . DO NOT use retired) | P | intail Point |
| 17 | d 2 filled Hygiv other | Be Co | 17. Father's Name (First, Middle, Last) | hun | d Scaping | e (First, Middle, Maide | arlnership an Sumama) |
| No | Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mandal Hygiene. Important: I flem 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Madical Example and injury of other treumatic event, the Madical Example and injury of the modified at | To B | Charles | Sampson | Della | sto | an Ford |
| 62 | lary 2 sho and h is ma | | 19a. Informant's Name/Relationship (Type, | Print) 19b. Mai | iling Address (Street and Number or Run | al Route Number, City | or Town, State, Zip Code) |
| Am pson | e, N t and tealth om 27 ther tr | | Patricia Samp 20a. Method of Disposition | Son-daughter 2 | 7 Village Circ | le Dent | Location - City or Town, State |
| 5 | Baltimore, permit. Pages 1 ar Department of Hea mportant: If item 3 nny injury or other | | 4 Oraniel A Commention A Comment | cemetery, cr | | | |
| | Itin | اند | * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee | Kobinsan | 1's Church Cem, 11-12 | -2005 G | rasonville, Md. |
| | Dem Pem Pem any | 93UG | 1 | | Bennie Smith Fun | neral Hom | ne 21/01 |
| | | | '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of | ions that caused the death. Do not en | inter the mode of dying, such as cardiac | or respiratory arrest, | Approximate Interval Between |
| | Pnysicia | n-e | Immediate Cause (Final disease or inition resulting in death) | ADVANCED | PANCREATK | CA | Onset and Death |
| | /Medica | | resulting in death) | Due to (or as a consequence of): | | | |
| | ZAGITITI | | Sequentially list conditions, if any, leading to immediate gauss. Enter Underlying | Due to (or as a consequence of): | | | |
| | uted d ansit | Examiner | Cause (Disease or injury | bus to (or as a consequence of). | | | |
| | O, exect an an rial-tra | | that initiated events c. resulting in death) Last | Due to (or as a consequence of): | | | |
| | 68760, ifficate be executed g physician and as the burial-transit | dical | d. | | | | |
| | | | IF FEMALE: | If you automa of programs. | | | |
| | Geath certif | Physiclan/Me | in the past 12 months? | | ☐ Ectopic pregnancy ☐ Other (specify) | | 23d. Date of delivery Month Day Year |
| | P.O. nat the d d by the letached | hysi | 1 Yes 2 No 9 Unknown | 9 Unknown | Curior (apachy) | | |
| | | by P | Part II. Other significant conditions contrib | | underlying cause given in Part I. | 23e. Did tobacco | use contribute to the cause of death? |
| | cord w require been six | | ACUTE RENAL | 1111-013- | | 1 ☐ Yes 2 | 2 □ No 3 □ Probably 4 X Unknown |
| | Aeco | Completed | HADERLENGI | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| | Vital Relicion: The I | | | NELITUI I | | performed? | death? 1 Yes 2 No |
| | of Vita Physicien: r this certifical | o Be | 25. Was case referred to medical examiner? 1 □ Yes 2 No Hosp | pital: 1 ★ Inpatient 2 □ ER/Outpatie | | Check onl one | . 504 |
| | on of Vital Reding Physicien: The In. After this certificate ha funeral director, page | | 27. Manner of Death | 8a. Date of Injury 28b. Time | of 28c. Injury at | me 5 Hesidence 28d. Describe how inju | occurred |
| | endin eath. or: Aff | atlo | 1 Natural 5 Pending investigation | (Month, Day Year) Injury | M 1 Yes 2 No | | |
| | Division of Vital Records, To the Hospital or Attending Physicien: The law requires I within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home, farm, s building, etc. (Specify) | street, factory, office | 28f. Location (Street a City or Town, Stat | and Number or Rural Route Number, te) |
| | spitel ours a nerel (filled | | 29a. Certifier 12 Certifying Physicia | an: To the best of my knowledge, dea | ath occurred at the time, date and place, | and due to the cause/ | c) and manner as stated |
| | ne Ho n 24 h ne Fu | edical | (Check only 2 Medical Examiner: one) | On the basis of examination and/or i and manner stated. | investigation, in my opinion, death occurr | ed at the time, date an | nd place, and due to the cause(s) |
| | To the To the To the Comp. | W | 29b. Signature and title of dertifer | | 29c. License number | | ate signed (Month, Day, Year) |
| | , | | 1011-0 | | 163726 | | 08.02 |
| | | | 30. Name and address of person who comp | | | | |
| | 9 | State | 31. Date filed (Month, Day Year) 1 4 2005 | TON STREET 32 Registrar's Signature | EASTON M | 10 216 | V 1 |
| | Regis | | MUN T 4 CAND | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 1al, 2005 ar 12:25 P Martha Maxine T. Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Care Center Frostburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 09-NOV-1921 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1□M 201F Days Hours Marvland Yrs. Director 217-14-4693 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
snt: If item 27 is marked other then "naturel", or Items 23a or 28a-f show 10h County 10a State 10c. City, Town or Location 27 is marked other then "naturel", or Items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Allegany Frostburg 1 ☐ Yes 2 No 10e. Street and Number 16307 Clarysville Road, S.W. 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21532-Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White ģ 3 ☑ Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ellis Teasdale Martha Ellen Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tree once. 16309 Clarysville Road 21532 Paula S. Moore Daughter Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 14-Nov-2005 Frostburg Saint Michael's Cemetery Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

4 S CURS Immediate Cause (Final ASPIRATION **Physician** ANeumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician are for use as the burial. P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. the 9 Unknown 9 Unknown \$ signed t Part II. Dther significant conditions contribution to death but not resulting in the underlying cause given in Part I.

SENILE Jemen T/A 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 20 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Tyes 2 No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATURNINA CHANG 4 BROADWAY nis 31. Date filed (Month, Day, Year) 32. Signature State NOV 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene-For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 18, 2005 Clare Shiells 9:15am M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Northampton Manor Nursing Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan 27, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 New York **Funeral** Months 1 ☐ M 2 🗙 F 061-09-0337 Director 96 Usual Residence of Decedent with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow 27 is marked other than "natural", or itama 23a or 28a-f ebov treumatic event. In a Medical Examinar must be notified at Maryland Frederick Frederick 1 ☑ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 East 16th Street 21701 U.S.A. deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within i Depertment of Health and Mental Hyglene. Importent: if Itam 27 is marked other than "reary injury or other treumatic event. The Med Elementary/Secondary (0-12) College (1-4or 5+) District Clerk Telephone Company 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Delanev Agnes Elizabeth ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. O'Neill - Nephew 8003 Clearfield Road, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory Nov 19,2005 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signature A Funeral Service Licens 23a. Part. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac prespiratory arrest, shock, or heart failure. List only one cause on each line. 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician INE GERELSWE enne /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural s effer de. •al Director: Ahe 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour. the Funerel Directory filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D58391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 801 Tollhouse Avenue C-3, Frederick, Maryland 21701-4555 Sajjed Aziz, M.D., 31. Date filed (Month, Day, Year) State NOV 2 9 2005 Registrar

| | | | 1 - For State Registrer | State of Maryland | | ent of Hea ate of De | | | piene 005 | 38453 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------|----------------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle, Last) | . (. 1 | | | | 2. Date of Dear | Day Year | 3. Time of Death |
| | /Media | cal | Roxanne F. Sh | | 1 | | | Novemb | per 22,20 | 05 11:06PM |
| 1 | Examir | er | 4a. Facility Name (If not institution, give si Johns Hopkin's Bo | ryview Medic | | by, Town, or Local Boultim | | | Baltim | |
| | Funeral Director | | 5. Social Security Number 6. Sex | 7. Age (In yrs. It | ast birthday) If Und Month | | Under 24 Hrs. ours Min. | 8. Date of Birth (Month, Day, November | Year) (| inthplace (State or Foreign Country) Aaryland. |
| | yland Iow | | 10a. State 10b. County | 10c. City | , Town or Location | | | | | 10d. Inside City Limits |
| | death with the Maryland me 23a or 28a-f ehow rroust be notified at | ctor | Pa. FRANKI | N 51 | +. Thom | AS | | | | 1 □ Yes 2 ☑ No |
| | vith th | Dire | 10e. Street and Number | . 0 | 10f. i | Zip Code | | 1 | 0g. Citizen of What (| Country? |
| | ne 234 | Funeral Director | 1894 McDow | 2. Was Decedent Ever in U.S | S. 13 Was Dec | 1725 | | ecify Yes or No- | 14. Race - An | |
| | be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "naturel", or iteme 23a or 28a-f ehow event, the Medical Examiner man be notified at | ρ | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | If Yes, s | pecify Cuban, Me | exican, Puerto | Rican, etc.) | Black, Wh | |
| 200 | 72 ho | eted | 15. Decedent's Educ (Specify only highest grade | ation completed) | 16a. Decedent's Us | sual Occupation work done during | n most of worki | na | 16b. Kind of Busines | s/Industry |
| 21215-0036 | within then then | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NOT | use retired) | , | | NIA | |
| | Hygid other | Be Co | 17. Father's Name (First, Middle, Last) | | 10/14 | 18. | Mother's Name | (First, Middle, M | Maiden Sumame) | |
| /lan | should be and Mental marked c | ToB | Leland J. | Shildt | | | DOREA | S FAV | E Bur | Kholder |
| Maryland | s 1 and 2 should 1 Health and Men Item 27 ie marke other traumatic | | 19a. Informant's Name/Relationship (Typ | • | | 909 | Number or Rura | l Route Number | City or Town, State. | Zip Code) |
| | s t and of Health item 27 other t | | 20a. Method of Disposition | 20b. Pl | 1896 Inco. | lame of | do 5 | T Thon | 20c. Location - City o | 1725Z |
| ē | 0 0 | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State | emetery, crematory o ers <u>Cem</u> | r other place) | 11/2 | | | |
| Baltimore, | permit. Pag Depertment Importent: I eny injury o | | 21. Signature of Funeral Service Licenses | | 22. Name | and Address of | Facility | 703 | Mercersb. Home gerstoon | wy /A |
| _ | 20 E 2 9 | | Souglas & Fr | ery | 1331 | Easteen | BIND | NERT HA | gerstown | md 21742 |
| | | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final | e cause on each line. | Do not enter the m | ode of dying, suc | ch as cardiac c | r respiratory arre | est, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | Extreme 1 Due to (or as a consequ | ence of | 1 | | | | |
| Н | Examiner | | Sequentially list conditions | Respirator | y failu | re Du | Imonai | y hyp | oplasia | |
| | sit sit | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (br as a consequ | 1 | | | 1.91 | | |
| _ | xecute and al-tran | Examiner | Cause (Disease or injury that initiated events c. resulting in death) Last | Yerinatal Due to (or as a consequ | olepre | ssion. | • | | | |
| 68760, | uires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit | edical E | L _d . | Possible | Sepsis. | | | | | |
| 89 | ng phy as th | | IF FEMALE: | | | | | | | |
| Box | attendi for use | lan/I | 23b. Was decedent pregnant in the past 12 months? | ic. If yes, outcome of pregnan | death 3 □Ectopic | | | | 23d. Date of de Month | Plivery Day Year |
| P.O. Box | the de y the a | Physician/M | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at time of de 9□ Unknown | eath 5 Other (| specify) | | | | |
| œ, G | ss that gned b | by Pt | Part II. Other significant conditions cont | nbuting to death but not resu | Iting in the underlying | cause given in I | Part I. | 23e. Did tob | acco use contribute | to the cause of death? |
| ord | w require been sign should b | ted | Congenital ane | mia, sho | ock, Hy | pogly | cemia | 1 □ Ye | s 212No 3□P | robably 4 Unknown |
| Division of Vital Records, | e law n has be | Completed | <u> </u> | | | , , | | 24a. Was ar autopsy | y prior to | utopsy findings available completion of cause of |
| E | in: Th | e Co | 25. Was case referred to medical | | | | | | No 1□Ye | s 2□No |
| $\bar{\mathbf{z}}$ | ysicia is cert directe | To Be | examiner? | ospital: 1 npatient 2 E | ER/Outpatient 3 1 | Other | | Check only one | nce 6 ⊡Other (Spe | acity) |
| 0 | ng Ph fter th ineral | | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | | | w injury occurred | ,, |
| Sio | ttendi death. stor: A the fu | Icati | 2 Accident investigation 3 Suicide 6 Could not be | On Blace of laising At hos | M | 1 ☐ Yes | | 26 1 (7) | | |
| 2 | tal or Attend 's after death si Director: , ed in by the f | Certification; | 4 Homicide determined | 28e. Place of Injury - At hor building, etc. (Specify) |) | огу, опісе | 4 | City or Town | reet and Number or R , State) | lural Houle Number, |
| | To the Hoepital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funestal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical | 29a. Certifier 1 ✓ Certifying Physi (Check only one) 2 ☐ Medical Examine | cien: To the best of my knower: On the basis of examination and manner stated. | vledge, death occurre on and/or investigation | d at the time, da | ate and place, a | nd due to the ca | use(s) and manner a ite and place, and du | s stated. e to the cause(s) |
| | To th within To the compl | Me | 29b. Signature and title of certifier | | i i | 9c. License num | | | d. Date signed (Mon | _ |
| | | | > //wif | -/MD | | D 00 4 | 1799 | 8 N | lovember | 23,2005 |
| | | | 30. Name and address of person o com | | 23a) (Type, Print) | | | | | |
| | Sta | te | JEANNE S. N 31. Date filed (Month, Day, Year) | JUNEZ, MD 22. Registrar's Signatu | ure A | | | | | |
| | Registr | | 31. Date filed (Month, Day, Year) NOV 2 S 2005 | as we so | Sales Sales | | | | | |

| Physic /Med | | Decedent's Name (First, Middle, La. | st) | 7-1-7-2 | 000 | - Trout | 0, 1 | Death | | 2. Date of | Reg. No | o | | 3 8 4 5 4 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------|--------------------------------------|---------------------------|----------------------|---------------------------|------------|-------------------------------|---------------------------|-----------------------|------------------------|-------------------------------------------|
| | | Vincent | Α. | | [erci | ionae | | | | Month Novem | Da | • | Year | 7:10P |
| Exami | | 4a. Facility Name (If not institution, give | | r) | .0101 | | Town, or | Location | of Death | | | c. County | | - 1 • LVI |
| Funeral | | 25605 Jarl Drive 5. Social Security Number 6. S | | Age (In yrs. Ia: | st birthday) | Gait If Under | her: | sburg If Under | 24 Hrs. | 8. Date of | Rirth | Moni | tgome | ry |
| Director | | 1 | X M 2□F | 69 | Yrs. | Months | Days | Hours | Min. | May 1 | Day, Year | | | place (State or Forei ntry) |
| and * | | 117 28 8555 Usual Residence of Decedent 10a. State 10b. County | | 10c City | Town or Lo | cation | | | | Hay I | J, 13 | JU | | |
| Marylan f show | ŏ | Maryland Montgo | morv | | thers | | | | | | | | | 0d. Inside City Limi: |
| h the | Directo | 10e. Street and Number | mery | Juli | Inclo | 10f. Zip | Code | | | | 10g. Ci | itizen of W | hat Cour | |
| 72 hours after death with the Maryland retural; or Items 23a or 28a-f show dical Exactiver rives to retilized at | a | 25605 Jarl Drive | | | | 2 | 20882 | 2 | | | | US | SA | |
| er dea Items | Funeral | 11. Marital Status | 12. Was Deceder Armed Forces | ? | . 13. | Was Deced If Yes, spec | ent of Hi | spanic Ori n, Mexicar | gin? (Spe | ecify Yes or Rican, etc.) | No- | 14. Race | | an Indian, etc. |
| irs aft | by F | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ If Nes, Give Year or Dates | | | 1 ☐ Yes 2 | | Specify: | | | | | Whit | |
| od within 72 hours aff giene. er than "natural", or the Medical Exami | ted | 15. Decedent's Ed | ducation | | 16a. Dece | dent's Usua | l Occupa | tion | | | 16b. K | (ind of Bu | | |
| ithin 7 | Completed | (Specify only highest gra | College (1-4or | r 5+) | life. I | kind of wor DO NOT us | e retired) | uring mos | t of worki | ng | | | | |
| iled w lygier ther th | S | 17. Father's Name (First, Middle, Last) | | | Er | nginee | | | | | | Veriz | | |
| d 2 should be file th and Mental Hy ?? is marked oth traumatic event | o Be | | | | | | | | | (First, Midd | | n Sumame | э) | |
| shoull nd Me mark mati | 2 | Vincas Terci 19a Informant's Name/Relationship (Alice Tercijonas | jonas Type, Print) | | 19b. Mailir | na Address | (Street a | Ond Numbe | na P | utvyte Il Route Nur | nher City | or Town | State 7in | Code) |
| alth a | | Alice Tercijonas Alice Tercijonas | | | | | | | | ersbui | | | | 20882 |
| permit. Pages 1 ar Department of Hea mportant: If item any injury of othe ance. | | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ | | | ce of Dispo | sition /Nam | a of | T I | | ate | - | ocation - (| | |
| Pag ment ant: I | | '4 □ Donation 5 □ Other (Specify | | | incol | n Cre | emato | ry | | /2005 | | | - | aryland |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury accident traumatic event, the Medical Examiner must be muttined at once. | | 21. Signature of Funeral Service Lio- | en en | z | | Name and | Address | of Facilit | Hine | es Rin | naldi Silve | Fune r Spr | ral | Home MD 20904 |
| /Medical Examiner business; International Properties of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the princip | dicai Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or a | astati s a conseque s a conseque | nce of): | al Ce | 11 | Carcí | noma | | | | | Onset and Death |
| that the death certifical ed by the attending phy detached for use as th | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal de | eath 3 | Ectopic pre | | | | | - | 23d. Date Mont | | y Day Year |
| es be | þ | Part II. Other significant conditions or | ontributing to death | but not resulti | ng in the ur | iderlying ca | use giver | n in Part I. | | | | | | e cause of death? |
| The law ate has b page 2 sl | Completed | | | | | | | | | | opsy formed? | pri de | or to corr ath? | sy findings available pletion of cause of |
| Physician: this certific ral director, | o Be | 25. Was case referred to medical examiner? | Hospital: | | | | Other | | | (Check only | - | | | - |
| ling After unel | H- | 1 ☐ Yes 2 【No 27. Manner of Death 1 【Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Inj (Month, Da | ient 2□EF ury 28 ay Year) | NOutpatient Bb. Time of Injury | | c. Injury : Work? | 4 L Nur | 2 | ne 5 X Re 8d. Describe | | | | |
| al or Attending s after death. Il Director: After id in by the fune | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 286. Place of in | ijury - At home tc. (Specify) | e, farm, stre | et, factory, | office | | 2 | 8f. Location City or T | (Street an own, State | d Number) | or Rural | Route Number, |
| To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by | edicai (| 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam | ysician: To the best iner: On the basis of and manner si | or examination | edge, death n and/or inv | occurred at estigation, i | t the time | , date and nion, deatl | place, a | nd due to th d at the time | e cause(s) e, date and | and mani place, an | ner as sta d due to | ted. the cause(s) |
| To the within. To the comple | | 29b. Signature and title of certifier | | | | 29c. | License | number | - <u>-</u> | | 29d. Dat | e signed (| Month, D | lay, Year) |
| 20 | | 1 / 195/ | | ~ | 9 | D | 3563 | 5 | | | Nove | ber | 7, 2 | 005 |
| 6 | | 30. Name and address of person who co | | death (Item 23 | | | D - | | | | | | | |
| | | | | · Prin | oo Uh | | | _ /\]. | | 4.5 | | 208 | | |

| | | | For State Registrar | State of M | Marylan | | artment rtificate | | | and Me | - | giene Rog. No. | 05 | 38455 |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------|--------------------------------------------|----------------------------|------------------------|--------------------|---------------|---------------------------------------|--------------------------|----------------------|----------------------------------------------------|
| | | | 1. Decedent's Name (First, Middle | e, Last) | | - | | | | | 2. Date of Dea Month | Day | Year | 3. Time of Death |
| 7 4 | Physici /Medic | | Ngoc Quy Tra | an | | | | | | - | Novemb | er 7, | , 2005 | 8:40 a M |
| | Examir | | 4a. Facility Name (If not institution | - | | | | | Location o | of Death | | | County of Death | |
| | | A 2 | Washington Adv | | | | Tako | | Yark If Under: | 0.4 Hrs. I s | | | ontgome | |
| 46 | Funeral Director | | 5. Social Security Number 218-94-8164 | 6. Sex 1 ☐ M 2 ☐ F | Age (In yrs. I | 97 Yrs. | Months | Days | Hours | Min. | Date of Birt (Month, Day Oct. I | 2, 19 | Col | place (State or Foreign intry) etnam |
| | A w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | r, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | Aarylan I show | ៦ | | - acmowit | c; | lver S | Enrina | | | | | | | 1 ☐ Yes 2 X ☐ No |
| | 28a-1 | ect | Maryland Mont | gomery | 91 | iver . | 10f. Zip | | | | | 10g. Citize | en of What Cou | intry? |
| | with Sa or | D | 8634 11th Ave | nue | | | 20 | 903 | | | | Ţ | USA | |
| | heath The 23 | Funeral Director | 11. Marital Status | 12. Was Decede | | S. 13. | | | spanic Orig | gin? (Spec | fy Yes or No- ican, etc.) | - 14 | 4. Race - Amer | |
| 36 | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Madical Examiner man be collined at | by Fun | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Force 1 Yes 2 If Yes, Give Year or Date | X No | | liYes, speci 1 ☐ Yes 2 | | | i, Puerto Hi | can, etc.) | | Black, White | ian |
| 21215-0036 | hour | edt | 15. Deceden | | | 16a. Dece | dent's Usual | Occupa | ition | | | 16b. Kind | d of Business/I | |
| 15 | in 72 | Completed | (Specify only higher | st grade completed) | | (Give life. | kind of worl DO NOT use | k doné d e retired) | uring most | t of working | 7 | | | · |
| 212 | s within jiene. r than | E | Elementary/Secondary (0-12) 12 | College (1-4d | or 5+) | Hon | nemake | r | | | | Own | Home | |
| | 3.2 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Men | a | 17. Father's Name (First, Middle, | Last) | | | | | 18. Mothe | r's Name (| First, Middle, | Maiden S | Sumame) | |
| an | lid be fenta rked rked | 0 | Unknown | | | | | | Unk | nown | | | | |
| Maryland | shou and N ama umat | | 19a. Informant's Name/Relations | hip (Турө, Print) | | 19b. Mailir | ng Address | (Street a | nd Numbe | or Rural | Route Numbe | er, City or | Town, State, Z | ip Code) |
| _ | 1 and 2 Health a tem 27 li | | Trinh N. Nguy, | / Son | | 8634 | llth | Aver | ue, | Silve | r Spri | ng, I | MD 2090 | 3 |
| Baltimore, | 2 = 2 W | | 20a. Method of Disposition 1 ★ Burial 2 Cremation 4 Donation 5 Other (S | | te C | tace of Dispo emetery, crei clawn Me | natory or ot | her place | . 1 | Da Novembe | er 11 | | ation - City or 1 | |
| Ħ | nit. Pa vartmen ortant: Injury | | 21. Signature o Funer Il Service | | | 1-22 | 2. Name and | d Addres | s of Facilit | 200 | uneral | | | Maryland |
| Ва | permit. Departi Import any inj | | (undrew | Cole | | 50 | 00 Uni | vers | sity | Blvd, | W, Si | lver | Spring | , MD 20901 |
| | Physician | | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition | omplications that cause only one cause on each | sed the death | Do not ent | er the mode | of dying | , such as | cardiac or | respiratory ar | rrest, | | Approximate Interval Between Onset and Death |
| N. C. | /Medical Examiner | | resulting in death) | Due to (or | as a consequ | uence of): | ante | n Zri | , 1 | sea | 20. | | | |
| - | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or | as a consequ | uence of): | | 0 | | | | | | |
| 8760, | cate be executed obysicien and the burial-transit | Icai Exa | resulting in death) Last | Due to (or | as a consequ | uence of): | | | | | | | | |
| 9 | ifficat g ph) as th | ed | | | | | | | | | | | | |
| .O. Box | The law requires thet the death certificate be executed to be been signed by the attending physicien and been a should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | 2 Fetal | death 3 | Ectopic pre Other (spe | | | | | 23 | 3d. Date of deliment | very Day Year |
| a | ires thet the signed by d be detact | þ | Part II. Other significant condition Acuste Rem | ons contributing to death | h but not resu | ulting in the u | nderlying ca | iuse give | n in Part I. | | 23e. Did to | | | the cause of death? |
| Ö | w requir been si should | ete | n i 1 to | 2000 | 4.5 | | | | | | 24a. Was | an. | 24h Mare au | opsy findings available |
| I Records, | | Completed | Triporter | sin | TWI | <u></u> | | | | | autop perfo | | prior to death? | ompletion of cause of |
| Vital | santific etor, | Be (| 25. Was case referred to medica examiner? | 1 4 M | | | | | | of Death | Check only o | nel | | |
| of V | Physician: this certific ral director, | 9 | 1 ☐ Yes 2 No | Hospital: | | ER/Outpatier | | | 4 🗀 190 | | | | Other (Spec | ıty) |
| ion o | Jing After fune | | 27. Manner of Death 1 Natural 5 ☐ Pendir 2 ☐ Accident investi | | njury Day Year) | 28b. Time o Injury | f 28 | Bc. Injury Work | at ? ∕es 2 🗍 | | d. Describe h | how injury | occurred | |
| Division | of the Direction | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | sined 286. Place of | Injury - At ho etc. (Specify | ome, farm, sto | reet, factory, | , office | | 28 | of Location (S City or Tox | Street and vn, State) | Number or Ru | ral Route Number, |
| | To the Hospitel within 24 hours a To the Funerel I completely filled | Medical (| | ng Physician: To the be Examiner: On the basis and manner | s of examina | | | | | | | | | |
| | To the Within To the comp | 2 | 29b. Signature and title of certifie | r I |) | | 29c. | License | number | , | | 29d. Date | signed (Month | , Day, Year) |
| | 1/ | | Mitto | nio H. | ly | Mon | J |)15 | 14 | 6 | | -11/ | 7105 | |
| | | 1 | 30. Name and address of person | who completed cause of | of death Item | 3a) (Type, | Print) And | tory? | o Cl. L | m. | P., | Ms | 70 0 | Gal |
| | | | 21 Date filed (Month Corr V | mercy | istrario Cino | ture | W | TU | wy | de | ing | Fre | 1 2 | 101 |
| ** | Sta Regist | | 31. Date filed (Month, Day, Year) | 2005 | istrar's Signa | ture | de d | | | • | V | | | |

| | | | 1 - For Stete Registrar | State of Ma | aryland / | | rtment of tificate of | | Mental Hy | giene | 0.05 | 38456 |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------|---------------------|-------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------|----------------------|----------------------------------------------------|---------------------------------------------------------------------|
| - | Physici /Medi | al | 1. Decedent's Name (First, Middle Lanes | Jackson | | Ti | .bbs | Sr | 2. Date of De Month Novemb | Day er 1 | 0, 2005 | 3. Time of Death 4:25pm M |
| | Examir Funeral | er | 5. Social Security Number | Memorial Hos | (In yrs. last b | ,, | - | | s. 8. Date of Bir (Month, Da | th y, Year) | Freder 9. Birti Co. | |
| | Director works 1-1 show | tor | 217-28-1509 Usual Residence of Decedent 10a. State 10b. County MD Fre | derick | 73 10c. City, Tov | Yrs. | ation | | APR 18 | | | es Garden VA 10d. Inside City Limits 1 X Yes 2 \(\subseteq \) No |
| | eath with the | Funeral Director | 10e. Street and Number 3513 Cemetery | | | | | 21758 | · | | zen of What Col | |
| 9000 | hours after de ural', or Item | by | 11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | o Korean | 1[| ⊇Yes 2∑XNo | Specify: | Specify Yes or No rto Rican, etc.) | ì | 14. Race - Amer Black, White Specify: Wh | e, etc. |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Modical Extending in will be not like at a page. | Completed | 15. Deceden (Specify only highe Elementary/Secondary (0-12) | College (1-4or 5- | +) | (Give ki life. D | nt's Usual Occu ind of work done O NOT use retire Driver | during most of w | orking | Schr | nd of Business/I rewman T ceystowr | rucking |
| Maryland | should be fill nd Mental Hy marked oth imatic event | To Be | 17. Father's Name (First, Middle, Henley A. Tib 19a. Informant's Name/Relations | bs | 191 | b. Mailing | Address (Stree | Margar | ame (First, Middle, et C. Shu Bural Route Numbe | ıpe | , | in Code) |
| ore, Ma | ges 1 and 2 t of Health a If item 27 Is or other trau | | Shirley A. Ti 20a. Method of Disposition 1 ③Burial 2 ☐ Gremation | | | 3513 | | ry Circl | e, Knoxvi | 11e, | | .758 |
| Baltimore, | permit. Pa Departmen Important: any injury | | 4 □Denation S □Other (S 21. Signatury 1 5 pour Service Barbara A. | 1 1 11 | -2 | Jo | Name and Addre | l Garden ess of Facility illiams | s Funeral H | lome | derick, | |
| | Physician /Medical | | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | a. Emphyse | ena | not enter | the mode of dyi | ng, such as cardia | ac or respiratory ar | rest, | K, FID 2 | Approximate Interval Between Onset and Death Years |
| 8760, | cate be executed physician and the burial-transit | dlcal Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Chronic Due to (or as a c. Due to (or as a d. | Obstri consequence | of): | ve Pulmo | onary Dis | sease | | | |
| .O. Box 6 | ath certifi ttending or use as | Physiclan/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ U⊓known | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at to 9 ☐ Unknown | Fetal death | | ctopic pregnanc Other (specify) | У | | 23 | 3d. Date of deliv Month | ery Day Year |
| ords, P. | w requires that the de been signed by the a should be detached f | þ | Part II. Other significant condition | ns contributing to death but | t not resulting i | n the und | erlying cause giv | ven in Part I. | | | | he cause of death? |
| Vital Records, | The ate h page | e Completed | 25. Was case referred to medical | | | | | | | sy med? 2 ☑ No | 24b. Were auto prior to co death? 1 ☐ Yes | ppsy findings available impletion of cause of 225 No |
| ō | ending Phys sath. or; After this he funeral di | ToB | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r | ation | Year) 28b. 1 | Time of njury | 28c. Injur Wor M 1 □ | er: 4 🗆 Nursing I | ath (Check only or Home 5 Resid 28d. Describe h | ence 6 | | (5y) |
| | spital or ours afte leral Dir filled in | | 4 Homicide determi | building, etc. | (Specify) | e death o | ccurred at the tir | me, date and place | City or Tow | n, State) | nd manner on | al Route Number, |
| | To the Hos within 24 h To the Fur completely | Medical | 29b. Signature and title of certifier | xeminer: On the basis of each manner state | ed. | YUT= | 29c. Licens | e number | 2 | 9d. Date | signed (Month, mber 11 | Day, Year) |
| 2+ | NA | | 30. Name and address of person of Alan H. Rohrer | , M.D, D.M.E. | ., 15 W | est | Seventh | Street, | | | | |
| | Sta Registra | e ır | 31. Date filed (Month, Pay, Year) | 2005 32. Figistrar | 's Signature | do | edi | | | · · · · · · | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiere 0.5For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Leo David Thrasher <u>10:</u>45a [™] Nov. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 308 Benfield Road Severna Park Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 1⊠M 2□F Months Yrs. Director 64 Dec. 9, 1940 212-38-1229 MD Usual Residence of Decedent the Maryland or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Severna Park MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 2 308 Benfield Road 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ō White other than "natural", o 1 ☐ Yes 2 🗵 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Anderson Oldsmobile Parts Manager 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of William Alvin Thrasher Susan E. Lepley ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan A. Thrasher/Wife f Health item 27 i 308 Benfield Road, Severna Park, MD Nov. 10, 2005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 0 = 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Parkwood Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Full ral Service Licensee Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146 11amy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) CORODART **Physician** ARTERT DISEASE YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Physician/Medicai use as 1 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death ed by the a 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ certificate hes been sign rector, page 2 should be PERLIPHERAL JASCYLAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy Division of Vital 1 Yes 2 No funeral director 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Lef or Att.

Turs after dean.

All Directors Att.
in by the fur-1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel of within 24 hours at To the Funerel D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1119105 D45643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOSE KELENEY # 550 MAZIL (250000 MO 410 MARICARY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 21201 NOV 0 9 2005 Registrar

DHMH 17 Rev 1/2001

Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Arthur James Tolson, Jr. 7:20 P M November 7, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ¥□ M 2□ F 579-18-9785 79 Vrs Oct. Director 1926 6, Washington, DC Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits injury or other treumatic event, the Medical Examinating to rediffied at a 1 ☐ Yes 2√€ No Maryland Montgomery Rockville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 5102 Macon Road 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other then "natural, or Ital 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943-47 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Cost Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur James Tolson, Sr. Thelma Mosell Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n Roberta K. Tolson/ Wife 5102 Macon Road, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 11, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Adress Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrhage 36 Hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attendii g physician and for use as the bur at-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Accelerated Hypertension, Coronary Artery Disease 1 Yes 2X No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Division of Vital 1 Yes 2 🗙 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2**x** No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 24 hours after death. 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Milail a. Waterman D52451 15+1 November 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Westerman, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814 32. aegistrar's Signature 31. Date filed (Month, Day, Year) NOV 14 State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1/1/05 14 20

Tolson, Arthur

| | | 1 - For State Registrar 1. Decedent's Name (First, Middle, Las.) | | partment of Health and ertificate of Death | Reg. N | 2005 38459 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| /Me | ician dical niner | ROBERT JOHN THOMP | SON_ street and number) | 4b. City, Town, or Location of Deat | November 5 | year 7:08 A M 2005 7:08 A M 2005 7:08 A M |
| Funei Direct | or | 5. Social Security Number 6. Se 565-14-4530 Lsual Residence of Decedent | x | Months Days Hours Min. | 8. Date of Birth (Month, Day, Yea Nov 10 191 | r) 9. Birthplace (State or Foreigr Country) |
| I 3-UU36 172 hours after death with the Maryland "natural", or Items 23a or 28a-f show | by Funeral Director | 12912 Ruxton Road 11. Marital Status 1 □ Never Married 2⊠ Married | | | Unit | itizen of What Country? ed States of Ameri 14. Race - American Indian, Black, White, etc. Specify: White |
| n 72 n | | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | Cation 16a. Dec (Giv 16b. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c. 16c | | rking | Kind of Business/Industry ESEArch n Surname) |
| permit. Pages 1 and 2 should be filed within pepartment of Health and Mental Hygiene. Important: If item 27 ia marked other than any injury or other traumatic event, Ire. | B source | 19a. Informant's Name/Relationship (T) Nancy J. Thompson 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens | Spouse 1291 Spouse 20b. Place of Disposementary, createry, createry, createry | 2 Ruxton Road, S1 consition (Name of ematory or other place) oln Crematory 11- | lver Spring Date Spring 200. L 12-2005 Brines-Rinald | , MD 20904 .ocation City or Town, State entwood, MD i Funeral Home, Inc |
| cate be executed cate be executed by Scician and physician and the burial-transit | Examiner | 23a. Part 1. Enter the disease, for complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, disay, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Respiratory Failu Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | or respiratory arrest, | Approximate Interval Between Onset and Death |
| death certifi e attending i id for use as | Physiclan/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | □Ectopic pregnancy □ Other (specify) | | 23d. Date of delivery Month Day Year |
| w requires that the been signed by th should be detache | þ | Part II. Other significant conditions con | tributing to death but not resulting in the o | underlying cause given in Part I. | 23e. Did tobacco | use contribute to the cause of death? □ No 3 □ Probably 4 ☑ Unknown |
| he law e has b age 2 sl | e Completed | 25. Was case referred to medical | | | 24a. Was an autopsy performed? 1 ☐ Yes 2√2 No | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| Attending Phyaician: If death. ector: After this certifice by the funeral director. | Certification: To B | examiner? 1 Yes 2 No 27. Manner of Death 12 Natural 5 Pending 2 Accident investigation | ospital: 1 XInpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury | nt 3 DOA Other: 4 Nursing H | th (Check only one) ome 5 Residence 28d. Describe how inju | |
| sepital or Attending Physician: Thours after death. Ineral Director: After this certificat y filled in by the funeral director, pr | | 3 ☐ Suicide 4 ☐ Homicide Could not be determined 29a. Certifier 1 ☑ Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certification Certific | 28e. Place of Injury · At home, farm, st building, etc. (Specify) ician: To the best of my knowledge, deal | th occurred at the time, date and place | City or Town, State |) and manner on stated |
| To the Hospital or A within 24 hours after To the Funeral Direct completely filled in bi | Medical | 29b. Signature and title of certifier | and manner stated. | 29c. License number | red at the time, date and | te signed (Month, Day, Year) |
| S Regis | itate strar | 30. Name and address of person who co | Ruban | Print) 1500 Fores | + 6/e4 1 | 167/05 road, Silver spring |

Division of Vital Records, P.O. Box 68760,

| | | 1 - For State Registrar | State of M | larylan | | artmen <i>rtificat</i> | | | nd Mei | | 2005 | 38460 |
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| Physicia | , an | Decedent's Name (First, Middle, Last) | 437 m47 | T OD | | | | | | Date of Death Month | Day Y | 3. Time of Death |
| /Medic Examin | | ORVILLE McCLELL 4a. Facility Name (If not institution, give s. | | LOR | | 4b. City, | Town, or | Location of | | VOV. | 13, 20 4c. County of | Death 17:10 M |
| LAMINI | | WASHINGTON COUNTY | HOSPITAL | 1 | | I | HAGE | RSTOWN | 1 | | | INGTON |
| Funeral Director | | 5. Social Security Number 6. Sex 1 🔀 | M 2□F 7. A | ge (In yrs 78 | last birthday) Yrs. | If Under Months | 1 Year Days | If Under 2 Hours | Min. | Date of Birth (Month, Day,) JG. 19, | 1927 | Birthplace (State or Foreign Country) MARYLAND |
| and w | | Usual Residence of Decedent 10a, State 10b, County | | 10c. Cit | y, Town or Lo | cation | | | | | | 10d. Inside City Limits |
| with the Marylan a or 28a-f ehow | tor | MARYLAND WASHING | ron | | | | В | OONSB | ORO | | | 1⊠Yes 2□No |
| th the or 28s | Director | 10e. Street and Number | | | | 10f. Zip | | 001.02 | <u> </u> | 100 | g. Citizen of Wh | at Country? |
| a 23a | rail | 18 DELLA LANE | 2. Was Deceden | t Ever in 11 | E 12 | Man Dann | | L713 | :-2 /Ci | Vac as Na | U.S | · A . American Indian, |
| after d | Funerai | 11. Marital Status 1 ☐ Never Married 2 ☒ Marned | Armed Forces | ? | +6- | _ | | | Puerto Ric | y Yes or No- an, etc.) | Black, | White, etc. |
| Su - H | d by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 196 | 0/ | 1 ☐ Yes | | Specify: | | 1 | Specify: | WHITE |
| 72 72 | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | completed) | E.\ | 16a. Dece (Give life. | tent's Usua kind of wo DO NOT us | rk done a | furing most | of working | 16 | 6b. Kind of Busi | ness/Industry |
| e filed within 72 al Hygiene. I other than "nat vent, the made | Com | 12 | College (1-4or | 5+) | MAIN | ENAN | CE M | ECHANI | | | | M MANUFACTURE |
| m = 0 5 | Be | 17. Father's Name (First, Middle, Last) | | | | | | | 's Name <i>(F</i> E E. S | | iden Sumame) | |
| permit. Pages 1 and 2 should bet Department of Health and Mental I Important: If item 27 ie marked of any injury or other traumatic evence. | ဠ | ORVILLE G. TAYLOR 19a. Informant's Name/Relationship (Type | e, Print) | | 19b. Mailir | ng Address | (Street a | | | | City or Town, St | ate, Zip Code) |
| and 2 Balth a n 27 l | | LORRAINE E. TAYLOR | /WIFE | | A | | | , BOON | |), MARY | LAND 2 | 1713 |
| Pages 1 nent of Huint: If iter | | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re | emoval from State | 1 ~ | lace of Dispo emetery, crer | sition (Nari natory or o | ne of ther place | · 1 | Date | | | ity or Town, State |
| artmer artmer ortant Injury | | 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Fuperal Service License | ө | BO | ONSBOR | | | Y 1. | | | | 0.MARYLAND al Pike |
| permit. Depart Import any in | | R | 77 | Zimme | В | | | AL HO | ME / | | nation o, Mary | |
| | | 23a. P. rt1. Piter / e disease, or complic shock in her it fairure. List in one | ations that cause e cause on each | ed the death line. | h. Do not ent | er the mod | le of dying | g, such as c | | | | Approximate Interval Bety een |
| Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | pred | valile | parly | inco | ide | al_ | info | eret | | Onset and Down |
| Examiner | | | ue to (or a | s a conseq | uence of): | | | | 1 | | | 1000 |
| Pe tis | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (u. a. | s ā Curis s q | ивпов оп). | | | | | | | |
| be executed sicien and burial-transit | Examiner | that initiated events resulting in death) Last | Due to (or a | s a conseq | uence of): | | | | | | | |
| cate be conversed the buri | dicai [| d. | | | | | | | | | | |
| entifica ding ph | Med | IF FEMALE: | to If you autoom | 0 01 040000 | | | | | | | | |
| leath certific attending p | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | c. If yes, outcom 1☐Live birth 4☐Pregnant | 2 Feta | death 3 | Ectopic pr | | | | | 23d. Date of Month | |
| at the de by the | hysi | 9 Unknown | 9□ Unknown | | | | | | · · · · · · · · · · · · · · · · · · | | | |
| se es es | þ | Part II. Other significant conditions conf | ributing to death | but not resi | ulting in the u | nderlying c | ause give | n in Part I. | | | | ute to the cause of death? |
| w requir s been si should | Completed | | | | | | | | | 24a. Was an | 24b. We | re autopsy findings available |
| The lay | Comp | | ***** | | | | | | _ | autopsy performe 1 ☐ Yes 2 ☑ | id? dea | re autopsy findings available or to completion of cause of ath? Yes 2 \sum No |
| ysician: Th is certificate director, pag | Be | 25. Was case referred to medical examiner? | nanital. | | | | 1 04- | | of Death (C | check only one) | | |
| Physi r this o | 7: To | 1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | ospital: 1 ☐ Inpat 28a. Date of Inj (Month, D | - | PVOutpatier 28b. Time of | | Othe 28c. Injury Work | 4 🗆 14013 | | | ce 6 Other | |
| nding I ath. r: After e funer | atior | 1 Natural 5 Pending 2 Accident investigation | (Month, D | ay Year) | Injury | М | | :? ∕es 2 🗆 N | | | . , | |
| or Attending Physician: After deading Dhysician: Director: After this certific, in by the funeral director, | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Ir building, e | njury - At ho | ome, farm, str V) | eet, factory | , office | | 28f. | Location (Stre City or Town, | et and Number State) | or Rural Route Number, |
| To the Hospital or Attending the Hospital or Attending 24 hours attended to the Euneral Director. Completely filled in by the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal states of the formal st | - | 29a. Certifier (Check only 2 Medical Examin | ician: To the bes | t of my kno | wledge, deatl | occurred | at the tim | e, date and | place, and | I due to the cau | se(s) and mann | er as stated. |
| the H hin 24 the F mplete | Medical | one) | and manner s | tated. | tion and/or in | | . License | | n occurred | | | |
| 19 10 | | 29b. Signature and title of certifier | | | | | Cicense | | 10 | 290 | ا کا را ا | Month, Day, Year) |
| 1241 | | 30. Name and address of person who cor | mpleted cause of | death (Item | 1 23а) (Туре, | | 0 | k | 8 | | 11/1/ | 0 |
| 13. | | Dr Shedenet | 21 | (N) | Mand | Do | | 140-9 | -116 | 1 21 | 750 | |
| Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 5 2005 | | trar's Signa | iure | الدائلية | | { | | | | |

| | | For State Registrar | State of Maryland / [| Department of H | | | 2005 | 38461 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------|
| Physic /Medi Examir | cal | 1. Decedent's Name (First, Middle, Last) Barry Ellev 4a. Facility Name (If not institution, give st | Tenne) | 4b. City, Town, o | Location of Death | 2. Date of Death Month Node who | Day Year | 3. Time of Death |
| Funeral Director | | 5. Social Security Number 6. Sex 20-72-1463 | Memory (CS) 7. Age (In yrs. last bir 45 | tritiday) If Under 1 Year Yrs. Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day,) 7 / 29 / 19 | | hplace (State or Foreign untry) 19Wood, WV |
| the Maryland 28a-f show | Director | 10a. State 10b. County WV Preston 10e. Street and Number | 10c. City, Tow Terra | n or Location A Alta 10f. Zip Code | | 100 | g. Citizen of What Co | 10d. Inside City Limits XXYes 2 □ No |
| th with 23e or | al Dir | 203 Willard Str | eet | 26764 | 1 | 1 | U.S. | |
| 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or items 23e or 28e-f show sumatic event, the Medical Exam or must be notified at | by Funeral | 11. Marital Status 1XXXever Married 2 Married 3 Widowed 4 Divorced | 2. Was Decedent Ever in U.S. Armed Forces? 1 | 13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No | lispanic Origin? (Spec an, Mexican, Puerto F Specify: | ify Yes or No- ican, etc.) | 14. Race - Ame Black, White Specify: W | |
| within 72 ho ane. than "natur the Medical is | Completed | 15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) | ation completed) 16a. College (1-4or 5+) | Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Homemake | during most of workin d) | g 16 | Sb. Kind of Business/ | |
| 2 should be filed within and Mental Hygiene. Is marked other than aumatic event. | To Be Co | 11th 17. Father's Name (First, Middle, Last) Charles Tenney | | nomemake | 18. Mother's Name | | <u>Domesti</u> ^{aiden Sumame)} n Tenney | |
| perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Departit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or liems 23e or 28a-f show any njury or other traumatic event; the Medical Examination of the follified at once. | • | 19a. Informant's Name/Relationship (Type Shannon Booker 20a. Method of Disposition 1 \text{\text{YBurial}} 2 \text{\text{Cremation}} 3 \text{\text{Re}} 4 \text{\text{Donation}} 5 \text{\text{Other}} (Specify) | 20b. Place o | o. Mailing Address (Street 03 Willard of Disposition (Name of any, crematory or other place Alta Ceme | Street | Terra 2005 | | V 26764 Town, State |
| permit. P Departme Importan any injurt | | 21. Signature of Funeral Service Licensed | Spean | 22. Name and Addre Arthur H. 105 High | ss of Facility Wright Land Aver | Funera | l Home rra Alta | , WV 26764 |
| Physician /Medical Examiner provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sician and provided in the sici | dical Examiner | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tany, leading to kinn collate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence | of): | ig, such as cardiac or | de metal | r, perteneum | Approximate Interval Between Onset and Death |
| To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physiclan/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown | n 3 □Ectopic pregnancy 5 □ Other (specify) _ | / | | 23d. Date of deli Month | ivery Day Year |
| quires that I | by | Part II. Other significant conditions cont | ributing to death but not resulting i | in the underlying cause giv | en in Part I. | | cco use contribute to | |
| The law recate has be page 2 sho | Completed | | | | | 24a. Was an autopsy performe | prior to death? | stopsy findings available completion of cause of 2 No |
| ysician ysician is certif director | To Be | 25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No | ospital: 1 Inpatient 2 ER/Ou | utpatient 3 DOA | 26. Place of Death ler: 4 ☐ Nursing Hom | | ce 6 🗆 Other (Spec | cify) |
| nding Ph th. : After the function of tuneral | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | | Time of Injury 28c. Injury World 1 | yat k? Yes 2 □ No | Bd. Describe how | injury occurred | |
| To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune. | Certiflcation: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home, fa building, etc. (Specify) | arm, street, factory, office | 2 | Bf. Location (Stre City or Town, | et and Number or Ru State) | aral Route Number, |
| le Hosp 24 hou la Fune letely fil | edical | | ician: To the best of my knowledger: On the basis of examination ar and manner stated. | | | | | |
| To the within To the Comp | Me | 29b. Signature and title of certifier | | 29c. Licens | 7925 | 290 | d. Date signed (Month | h, Day, Year) |
| | | 30 North the s | npleted cause of death (Item 23a) | (Type, Print)) Maryland | 71550 | | 1.100 | |
| St Regist | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | Anall 1 | | | | |

| | | • | 1- State of Maryl | | artment of H rtificate of I | | | iene | 5 | 38462 |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------|--------------------------------------------|----------------------------------------|--------------------------------------|---------------------|------------------------------------------------|
| * | .8. | 强 | Decedent's Name (First, Middle, Last) | | | | 2. Date of Dea Month | • | Year | 3. Time of Death |
| | Physici /Medic | | VIVIAN KINNIARD THOMA | S | | | 11 | 16 05 | | 00:35 AM |
| $\sum_{i=1}^{n}$ | Examin | | 4a. Facility Name (If not institution, give street and number) | | | Location of Death | | Allec | | 1 |
| | ٠, | | Sacred Heart Hospital 5. Social Security Number 6. Sex 7. Age (In) | yrs. last birthday | | ECCUT | 8. Date of Birth | | | ace (State or Foreign |
| | Funeral Director | | 15℃ M 2 F | Yrs | Months Days | Hours Min. | (Month, Day JULY 13 | , Year) | Coun | rucky |
| A | | | 407-44-4859 70 Usual Residence of Decedent | | | | OULT 13 | 1933 | | |
| | rylan | _ | 10a. State 10b. County 10c | . City, Town or L | ocation | | | | 10 | 0d. Inside City Limits 1 ☐ Yes XXNo |
| | Ba-f e | Director | WV MINERAL | KEYSER | | | | | | |
| | with th | Dire | 10e. Street and Number | | 10f. Zip Code | | 1 | 0g. Citizen of Wi | nat Coun | try ? |
| | death with the Maryland ms 23s or 28s-f ehow | erai | ROUTE 1, BOX 128 C | nIIS 13 | Was Decedent of H | | ecify Yes or No- | U.S.A | | an Indian. |
| | ther de | Funerai | 11. Marital Status 1 Never Married 2 Married 1. Was Decedent Ever Armed Forces? 1. Yes 2 No | 110.3. | If Yes, specify Cuba | an, Mexican, Puerto | Rican, etc.) | | , White, | |
| 99 | within 72 hours after ene "netural", or ite the madical Exemple | by | 3 Widowed 4 Divorced It Yes, Give Year or Dates: | | 1 ☐ Yes X☐ No | Specify: | | Specify: | WH | ITE |
| 5-0036 | 72 ho natur | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Dece | edent's Usual Occup | ation during most of work | ring | 16b. Kind of Bus | | • |
| 2121 | atthin ned | ηpi | Elementary/Secondary (0-12) College (1-4or 5+) | | DO NOT use retired TY CONTRO | • | TOD | | | ALLISTICS |
| 2 | led w tygier her ti | | 17. Father's Name (First, Middle, Last) | QUALII | II CONTRO | 18. Mother's Nam | | LABORAT | | |
| Maryland | ould be filed v Mental Hygie wrked other t | Be | VIVIAN S. THOMAS | | | | LEE LA | | , | |
| Ž | 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. Is marked other then "natural", or items 23s or 28s-1 show aumatic event, the Madical Examiner must be motified at | 은 | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mail | ing Address (Street | | | | tate, Zip | Code) |
| - | 2 6 9 5 | | AUDREY THOMAS / WIFE | ROUT | E 1, BOX | 128 C. K | EYSER. W | V 26726 | 5 | |
| e, | es 1 and 3 of Health fitsm 27 r other tr | | 20a. Method of Disposition 20 | b. Place of Disp | osition (Name of matory or other place | | | 20c. Location - C | | wn, State |
| altimore, | Pages nent of int: if it iry or o | | 1 🔁 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) M | | BAPT. CH. | 1 | 9/2005 | FORT A | ASHBY | Y, WV |
| Balti | permit. Page Department Important: if eny injury o | | 21. Signature of Funeral Sanice Licentee | 1 | 2. Name and Addres | ss of Facility FUNERAL | HOME, I | NC. | | |
| × | | | 23a, Part1. Enter the disease, or complications that caused the | leath. Do not en | P.O. BOX | 1260, F(| ORT ASHB or respiratory arr | Y, WV 2 | 2671. | Approximate |
| * | | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | <u>.</u> | | | | | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) Due to (or as a con | sequence of): | m par | | | | en | motile |
| 1676 | Examiner | | | , | 4 | | | | | |
| | п = | ner | if any, leading to immediate cause. Enter Underlying Due to (or as a con | sequence of): | | | | | | |
| | and trans | Examin | Cause (Disease or injury that initiated events c. | | | | | | | |
| 60, | cate be executed physician and the burial-transit | | resulting in death) Last Due to (or as a con | sequence or, | | | | | | |
| 98760 | cate phy: the | dicai | d | | | | | | | |
| ŏ | death certifii e attending p id for use as | /Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant | | | | | 23d. Date | of delive | ry |
| ă | death a atter d for u | Physician/M | in the past 12 months? 1 Vec. 3 No. 4 Pregnant at time | | ⊒Ectopic pregnancy □ Other (specify) | <i>!</i> | | Mont | h | Day Year |
| o. | t the c by the | hys | 9 Unknown | | | | | | | |
| s, D | The law requires that the de tie has been signed by the a bage 2 should be detached f | by P | Part II. Other significant conditions contributing to death but not | resulting in the | underlying cause giv | en in Part I. | | ~ | | e cause of death? |
| ğ | w require been signature | | confirmingsthy | | | | 1 🗆 Yı | es 2X No | Proba | ably 4 Unknown |
| Records, | e law r has be ge 2 sh | Completed | _ stail fibilition | | | | 24a. Was a autops | sy pr | or to con | osy findings available npletion of cause of |
| | | Con | real insufficiency | | | | perform 1 Yes | | eath? | 2□ No |
| Vital | ysician: The is certificate hadirector, page | Be | 25. Was case referred to medical examiner? Hospital: | | et all poal Oth | 26. Place of Deat | | | | |
| | Attending Physician: It death. ector: After this certific by the funeral director, | .: To | 27. Manner of Death 28a. Date of Injury | 2 ER/Outpatie | of 28c. Injur | y at | ome 5 Reside | | | ") |
| Division of | nding th. : Afte fune | tion | Natural 5 Pending (Month, Day Yea | r) Injury | Wor | k? Yes 2 ☐ No | | | | |
| N | Attendi or death. ector: A by the fu | ifice | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (Sp. | At home, farm, st | treet, factory, office | | 28f. Location (Si City or Town | treet and Number | r or Rura | Route Number, |
| | ital or rs afte al Dir led in | Certification: | Suiding, see, (sp | | | | | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medicai | 29a. Certifier Check only one) Gentifying Physicien: To the best of my (Check only one) Medical Exeminer: On the basis of exam and manner stated. | knowledge, dea mination and/or in | th occurred at the tin evestigation, in my o | me, date and place, pinion, death occur | and due to the c red at the time, d | ause(s) and man ate and place, ar | ner as stand due to | ated. the cause(s) |
| | o the | Mec | 29b. Signature and tyle of certifier | | 29c. Licens | e number | 2 | 9d. Date signed | (Month, I | Day, Year) |
| | 1 | | > Stun (L X thru | | NEE | 18116 | | 11/16/ | - | |
| | 10 | | 30. Name and address of person who completed cause of death | (Item 23a) (Type | Print) Sefon | 0. | 10 | 0 | 0. | |
| | nas | | 31. Date filed (Month, Day, Year) 32. Degistrar's S | _ | seton. | or co | mbertas | × MO | 215 | 02 |
| * | Sta Registr | | NOV 1 8 2005 | J. A | park | | | | | |

| | | | For State Ragistrar | State of M | aryland / D | epartment Certificate | | | and M | | giene | 005 | 38463 |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------|---------------------------------|-------------------------------------|------------------------------------|--------------------|---------------------|------------|---------------------------------|-------------------|-----------------------|------------------------------------|
| | | | Decedent's Name (First, Middle, La. | st) | | | | | | 2. Date of Dea | ith | | 3. Time of Death |
| Н | Physicia /Medic | | Hattie Maxin | e Unge | er | | | | | Month Noveml | Day | Year 9, 2005 | 5:00 P M |
| } | Examin | | 4a. Facility Name (If not institution, give | | | 4b. City, | Town, or | Location o | f Death | 21070111 | | County of Death | J. 00 - |
| | | | 179 Gank Road | | | | | 0akla | and | | | Gar | rett |
| | Funeral | | 5. Social Security Number 6. S | ex 7. Ag ☐ M 2∑IF | e (In yrs. last birth | Months | 1 Year Days | If Under 2 Hours | | 8. Date of Birth (Month, Day | Year) | 9. Birth | nplace (State or Foreign untry) |
| | Director | } | 220-52-9722 | UM ZWF | 79 Y | S. | | | | Oct. 14 | | | st Virginia |
| | and * | } | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | | | | 10d. Inside City Limits |
| | /anyli | ō | | 4 34 A 45 | , | | 0 | | | | | | 1 ☐ Yes 2 🛣 No |
| | 28a- | rect | 10e. Street and Number | rrett | | 10f. Zip | | kland | · | | 10a. Citiz | en of What Co | untry? |
| | 3a or | ٥ | 179 Gank Road | | | | | 21550 | | | | | • |
| | ms 2: | era | 11. Marital Status | 12. Was Decedent | Ever in U.S. | 13. Was Deced | | | | cify Yes or No- | 1 | USA 4. Race - Amer | ican Indian, |
| 9 | after or Ita | F | 1 Never Married 2 Married | Armed Forces? | | | | | , Puerto I | Hican, etc.) | | Black, White | e, etc. |
| 93 | 72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show diest Evantiner must be notified at | d by | 3 ⊠Widowed 4 □ Divorced | If Yes, Give Year or Dates: | | 1 🗆 Yes 2 | Z ZZI NO | Specify: | | | | Specify: Wh | ite |
| 21215-0036 | 72 h 'natu | Completed by Funeral Director | 15. Decedent's Ed (Specify only highest gra | | 1 (| ecedent's Usua Give kind of wor | k done d | urina most | of workii | ng | 16b. Kin | d of Business/l | ndustry |
| 121 | within ne. | mp | Elementary/Secondary (0-12) | College (1-4or | 5+) | ife. DO NOT us | | | | | | | |
| 7 | lled w lygie har t | Ŝ | 7th 17. Father's Name (First, Middle, Last) | | | Ног | ısew: | | de Nome | /Cinet Adiololle | Adaidan (| Home | <u> </u> |
| anc | ntal H | Be | 9111111111111 | | | | | 16. MOUTH | rsivame | (First, Middle, | Malden S | sumame) | |
| ž | d Mel d Mel mark | ၉ | William Herb 19a. Informant's Name/Relationship (| | inebaugh | Mailing Address | (Strant a | Agne | | Pearl | | Mason | in Code) |
| Maryland | d 2 s th an th an traur | | Lillie Beckman/I | | | | | | | | | TOWN, State, Z | ip Code) |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any njury or other traumatic event, the Medical Evantiner must be notified at once. | 1 | 20a. Method of Disposition | augnter | 20b. Place of [| Gank Resistance (Name | ne of | | | , Md. 2 ate | 155() 20c. Loc | ation - City or 1 | Town, State |
| Baltimore, | ages ant of t: If if | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif | | | crematory or ot | | ! | | | | 500V 3500 | |
| 薑 | artme orten njur | | 21. Signature of Funeral Service Licer | | Deer Pa | 22. Name and | tery d Addres | s of Facility | 11/1: | | | | Maryland |
| B | Departiment of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession of the concession | I | > Reduce A | Ver 1 | | Stewart | Fiir | neral | Home | | | Second | |
| | | | 23a. Part1. Enter the disease or com | plications that caused | the death. Do no | | | | | | | ira, ira. | Approximate Interval Between |
| В | Pnysician i | | shock, or heart failure. List only Immediate Cause (Final | | estive H | art Fai | l lure | 0 | | | | | Onset and Death |
| | /Medical | | disease or condition resulting in death) | a | a consequence of | | LLUI | Ε | | | | | Years |
| ı | Examiner | | Sequentially list conditions, | Arte | rioscler | tic Car | cdio | vascu. | lar 1 | Heart D | isea | se | Years |
| | p = | ner | cause (Disease or injury | Due to (or as | à consequence of | | | | | | | | |
| | ecute and trans | Examiner | that initiated events resulting in death) Last | C. | | | | | | | | | |
| 8760, | zate be executed hysician and the burial-transit | 區 | | Due to (or as | a consequence of | • | | | | | | | |
| | physics the | dlcal | | _ d | | | • | | | | | | |
| 9 X | death certific e attending p id for use as i | Physiclan/Med | IF FEMALE: | 23c. If yes, outcome | of pregnancy | | | | | | 25 | 3d. Date of deli- | /AD/ |
| Box | atter I for u | clar | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No | | 2 Fetal death | 3 ☐ Ectopic pre | | | | | | Month | Day Year |
| o. | 0 00 | ysi | 9 Unknown | 9□ Unknown | | | ,, | | | | | | |
| Δ. | res that igned b be deta | by PI | Part II. Other significant conditions of | ontributing to death b | out not resulting in t | ne underlying ca | use give | n in Part I. | | 23e. Did to | bacco us | e contribute to | the cause of death? |
| rd | w require been sig should b | ed t | Diabetes Melli | tus | | | | | | 1 □ Y | es 2 🗆 | No 3□Pro | bably 4 Unknown |
| Records, | law requires that the as been signed by th 2 should be detache | plet | | | | | | | | 24a. Was a | | 24b. Were aut | opsy findings available |
| Ä | The lavate has | Completed | | | | | | | | autops perfor | ned? 2M No | death? | ompletion of cause of |
| Vital | ysician: The is certificate hadirector, page | Bec | 25. Was case referred to medical examiner? | | | | | 26. Place | of Death | (Check only or | | | |
| of V | Physician: r this certific ral director, | 2 | 1 ☐ Yes 2 No | Hospital: 1 ☐ Inpatie | | atient 3 DO | A Othe | r: 4 🗆 Nur | rsing Hon | ne 5 Resid | ence 6 | Other (Spec | ify) |
| п | ng Ph Ifter th | ii o | 27. Manner of Death 1. Natural 5 Pending | 28a. Date of Inju (Month, Da | ıry 28b. Tir y Year) Inj | | Bc. Injury Work | at ? | 2 | 8d. Describe h | | | |
| sio | tendi leath. tor: A the fu | catl | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b | | | М | | res 2□N | | | | | |
| Division | or At | Certification: | 4 Homicide determined | 28e. Place of Inj | ury - At home, farr c. (Specify) | i, street, factory, | , office | | 2 | City or Tow | | Number or Hui | al Route Number, |
| _ | To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral | | 29a. Certifier Cartifying Ph | ysician: To the best | of my knowledge | feath occurred a | at the tim | e date and | d niace o | nd due to the o | ause/s) s | and manner as | stated |
| | 24 hos 24 hos a Fun etely | edical | (Check only 2 Madical Exap | piner: On the basis of | f examination and/ | or investigation, | in my op | inion, deat | h occurre | d at the time, d | ate and p | place, and due | to the cause(s) |
| | Fo the | Me | 29b. Signature and title of certifier |) | | 29c. | License | number | | | 9d. Date | signed (Month | , Day, Year) |
|) | , [0 | | +(1) | un | | | 1 |) (I | 33 | 3 | 111 | 11/01 | |
| | 10 | | 30. Name and address of person who | completed cause of c | feath (Item 23a) (T | /pe, Print) | | | | | 1 1 | - / 1 0 - | , |
| _ | 4 | | Dr. Thomas Johns | on, MD | 311 N. Fo | urth St | ., 0 | aklar | nd, N | faryland | 1 21 | L550 | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registr | ar's Signature | 4 | | | | | | | |
| | Registra | 777 | HOV I'M | LUUJ | - AT | Booch! | pr. | | | | | | |

| | | | 1 - State of Maryland / Depart Registrar Certifi | tment of Health and M ficate of Death | ental Hygier | ZHH5 BRU5U | |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------|----------|
| | | | Decedent's Name (First, Middle, Last) | | 2. Date of Death | 3. Time of Death | _ |
| ı | Physici /Medic | | Nellie Mary Uchic | | | Day 2005 1:30 A M | |
| | Examin | | | b. City, Town, or Location of Death | | 4c. County of Death | |
| | | | Garrett County Mem'l Hospital | Oakland Funder 1 Year If Under 24 Hrs. | 9 Date of Birth | Garrett | |
| | Funeral Director | | | Months Days Hours Min. | 8. Date of Birth 11/01/19 | 9. Birthplace (State or Foreign Country) WV | |
| | | | Usual Residence of Decedent | | | | _ |
| | show | <u>_</u> | 10a. State 10b. County 10c. City, Town or Locati | tion | | 10d. Inside City Limits 1 √2 Yes 2 □ No | |
| | he Ma 28a-1 | Director | WV Tucker Davis | 10f. Zip Code | 100 | Citizen of What Country? | |
| | with the same | | Fairfax Avenue | 26260 | | JSA | |
| | death ms 23 | Funerai | | s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I | | 14. Race - American Indian, | |
| 36 | within 72 hours after death with the Maryland ene. than 'natural', or Itams 23a or 28a-1 show ta Madrail Examiner must be notified at | by Fur | 1127 Never Married 2 ☐ Married 1127 Yes 2 ☐ No. | es, specify Cuban, Mexican, Puerto i] Yes 2[X No <i>Specify:</i> | Hican, etc.) | Black, White, etc. Specify:White | |
| 21215-0036 | 2 hou | | 15. Decedent's Education 16a. Decedent | t's Usual Occupation | 16b. | . Kind of Business/Industry | |
| 215 | d within 72 ho giene. Ir than "natu | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | d of work done during most of workir NOT use retired) | ng . | | |
| 121 | 77 75 15 15 | | | istered Nurse | (First, Middle, Maid | | _ |
| Maryland | 0 5 0 | To Be | 17. Father's Name (First, Middle, Last) Joseph Stanley Uchic | | e Gadzal | | |
| ary | s 1 and 2 should be f Health and Mental item 27 is markad othar traumatic ev |) - | | Address (Street and Number or Rura | | | |
| | 무를 2 급 | | | Box 474 Davis, | | | |
| Baltimore, | ges 1 a t of Hea If item or othe | | 20a. Method of Disposition 1 Removal from State 20b. Place of Disposition 1 Removal from State | ory or other place) | | Location - City or Town, State | |
| Iţi | it. Pa rtmen rtant: njury | | `4 □Donation 5 □Other (Specify) Cemetery | 11/1 | | omas, WV | - |
| Ba | permit, Pages 1 Department of H Important: If ite any injury or ot once. | | J. Scott Hinkle P. | ameard Address of Facility al l NKIE Funeral l O. Box 186 Day | Home, In vis, WV | 26260 | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. | the gode of dying, such as cardiac o | 1 1 | Approximate Interval Between On, et and Death | |
| | Pn ysicia n /Medical | | Immediate Cause (Final disease or condition resulting in death) | Mydearda | Hara | MON hrs. | 10/1 |
| В | Examiner | | Due to (or as a consequence of): | 1 | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying. Due to (or as a consequence of): | | | | |
| V | acuted nd transi | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | |
| 8760, | sate be executed physician and the burial-transit | | resulting in death) Last Due to (or as a consequence of): | | | | |
| 687 | sate ohy: | edicai | d | | | | |
| Box (| eath certific attending p for use as | n/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | 23d. Date of delivery | |
| | the death certifii y the attending p iched for use as | Physician/M | in the past 12 months? 1 Yes 2 No No No No No No No No | topic pregnancy ther (specify) | | Month Day Year | |
| P.0 | # O # | Phy | 9 ☐ Unknown Part II. Other significant conditions contributing to death but not/esulting in the unde | arthing course guide in Part I | 23a Did tohacc | o use contribute to the cause of death? | \dashv |
| | | d by | Ougostul Heart | Folle | 1 🗆 Yes | V | |
| Vital Records, | law requires as been sign 2 should be | Completed | | / | 24a. Was an | 24b. Were autopsy findings available | |
| Re | 0 5 0 | dwc | | | autopsy performed? | prior to completion of cause of death? | |
| ta | ician: The certificate rector, pag | a) | 25. Was case referred to medical | 26. Place of Death | (Check only one) | NO TOTES ZONO | - |
| Į V | Physician: this certific ral director, | ToB | examiner? 1 Yes 2 Yoo Hospital: 1 Inpatient 2 ER/Outpatient | 3 DOA Other: 4 Nursing Hon | ne 5 🗆 Residence | 6 ☐Other (Specify) | |
| o u | Ing Pl | | 27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury | Work? | 28d. Describe how in | jury occurred | |
| sio | tendi death, tor: A the fu | cati | 2 Accident investigation 3 Suicide 6 Colud not be 28e. Place of Injury - At home, farm, street, | M 1 Yes 2 No | Paf Location (Street | and Number or Rural Route Number, | - |
| Division of | after after Dirac | Certification: | 4 Homicide determined building, etc. (Specify) | , factory, office | City or Town, Sta | | |
| | To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors. | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (Check only 2 Medical Examiner: On the basis of examination and/or invest | ccurred at the time, date and place, a | and due to the cause | (s) and manner as stated. | |
| | tha hin 24 tha F tha F | Medical | one) and marker stated. | 29c. License number | | Date signed (Month-Day, Year) | _ |
| | To To | _ | 29b. Signature and tuts of capiflier | D23989 | 230. L | 11.16.05 | |
| , | | | 30. Name and address of terson who completed cause of death (Item 23a) (Type, Principle) | | 55 | 1.61-1 | 21 |
| | 3 | | Jutta D. Heiner | rarrett C | o. Mes | m'/ Hospital | |
| 7,67 | Sta | | 31. Date filed (Month, Day, Year) 32. Degistrar's Signature | <i>M</i> . | | | |
| | Registr | ar | NOV 2 9 2005 Brown & Special | WW. | | | |

| | | - | _ 101 | partment of Health and Mer partificate of Death | ntal Hygien | |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | 2. | Date of Death | 3. Time of Death |
| | Physicia /Medic | | GIUSEPPE ARTURO VIGNOLA | N | Month D November | 8 2005 12:50 P M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | c. County of Death |
| | | • | Holy Cross Hospital | Silver Spring | | Montgomery |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda; 12 | | Date of Birth (Month, Day, Yea | |
| | Director | - | 579.50.1008 88 Yrs. Usual Residence of Decedent | J | une 12,1 | 917 Italy |
| | /land | | 10a. State 10b. County 10c. City, Town or | Location | | 10d. Inside City Limits |
| | Many a-f sh | tor | Maryland Montgomery Boyds | | | 1. ⚠ Yes 2 ☐ No |
| | th the | Director | 10e. Street and Number | 10f. Zip Code | 10g. C | Citizen of What Country? |
| | 23a | rai | 22641 Shiloh Church Road | 20841 | U. | S.A. |
| Maryland 21215-0036 | within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-f show The Marical Ever's act must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ Moorted If Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric □ Yes 2 No Specify: | y Yes or No- ean, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White |
| 2-0 | 72 ho natur fical | Completed | 15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv | edent's Usual Occupation | 16b. | Kind of Business/Industry |
| 2 | within ene. than " | npie | Elementary/Secondary (0-12) College (1-4or 5+) | re kind of work done during most of working DO NOT use retired) | _ | |
| 7 | filed w Hygier Ather th | | | trepreneur | | Delicatesen |
| and | ed fall be | Be | 17. Father's Name (First, Middle, Last) Unknown | 18. Mother's Name (F Maria I | onegri | an Sumame) |
| Z | s 1 and 2 should be f of Health and Mental B item 27 Is marked of other traumatic eve | 2 | | iling Address (Street and Number or Rural R | | or Town, State, Zip Code) |
| Ma | od 2 s lth ar 27 ls r trau | 1 | | 9 Castlewood Court, | • | |
| ē, | s 1 and 2 of Health a item 27 Is other trau | | | position (Name of Pater ematory or other place) | | Location - City or Town, State |
| J0 | Pages nent of unt: If it | | 1 Burial 2 XI Cremation 3 Bemoval from State | coln Crematory 11/12/ | /2005 Bre | entwood, Maryland |
| Baltimore, | permit. Pages Department of I Important: If ite any injury or of | | 21. Signature of Funeral Service Licemee | 22. Name and Address of Facility IINES-RINALDI FUNERAL 1800 New Hampshire A | L HOME, I | INC. |
| 8760, | whysician and hysician and the buriat-transit | dical Examiner | 23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or head affore. List only one cause on each line. Immediate dause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aspiration Pneumo Due to (or as a consequence of): Dementia Due to (or as a consequence of): C. Due to (or as a consequence of): | | | Approximate Interval Between Onset and Death |
| .O. Box 6 | The law requires that the death certificate be executed the sas been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medic | | B⊟Ectopic pregnancy B☐ Other (specify) | | 23d. Date of delivery Month Day Year |
| S, Р | es that igned b | by P | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | | o use contribute to the cause of death? |
| ecords, | w require been si should b | ted | Deep Venous Thrombois | | 1 🗆 Yes | 2 ☑ No 3 ☐ Probably 4 ☐ Unknown |
| Vital Reco | | Completed | AAA | | 24a. Was an autopsy performed? | |
| /ita | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? Hospital: | 26. Place of Death (C | | |
| of | shys this al di | 2 | 1 ☐ Yes 2 🛣 No rouspital. 1 🖾 Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time | | 5 Residence d. Describe how in | 6 ☐Other (Specify) |
| UC. | ding After fune | ion | 1 X Natural 5 ☐ Pending (Month, Day Year) Injury | | a. Describe now in | ury occurred |
| Division | r Attender deat | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined 1 Homicide 1 At home, farm, building, etc. (Specify) | | Location (Street City or Town, Sta | and Number or Rural Route Number, te) |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | Medical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and mannel stated. | | | |
| | Vithir To th comp | Me | 29b. Signature and title efficients | 29c. License number | | Date signed (Month, Day, Year) |
| | 10 | | > >1 < X | D-62571 | Nov | vember 8, 2005 |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Typ Sarah Bromeland, M.D., 1500 Forest | Glen Road, Silver Sp | pring, Ma | aryland 20910 |
| | Sta Regist | | 31. Date filed (Month, Day, Year) NOV 1 4 2005 | Sparke) | | |

| ет '574 | A. var | gas | For | S | State of Ma | | d / Dep | artme | | th and N | | gien | | 201.66 |
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| | | _ | State Registrar | | | | Ce | rtifica | te of Dea | ath | T | Reg. No | ,000 | 38466 |
| *** | Physicia /Medic | | 1. Decedent's Name (First, Mide Miguel | | ejandro |) | Varg | as | | | 2. Date of De Month Novemb | Da | | 3. Time of Death 10:20 P M |
| | Examin | | 4a. Facility Name (If not instituti | on, give stre | et and number) | | | 4b. Cit | , Town, or Loca | tion of Death | | 40 | . County of De | ath |
| | ¥ . | | Howard County 5. Social Security Number | Genera | | | ast birthday | | lumbia eriyear lifu | Inder 24 Hrs. | 8 Date of Bi | | Ioward | rthplace (State or Foreign |
| | Funeral Director | | 228-81-2803 | | 2 F 7. Ag | 19 | Yrs. | Months | | ours Min. | 8. Date of Bi (Month, Di | | | icaragua |
| 3 de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la consta | | | Usual Residence of Decedent | 1 | | | | <u> </u> | | | INOV. | 6. | 1 2 0 3 14 | |
| | filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28e-f ehow thit, the Medical Exarting finish tencified at | or | MD 10b. Count How | | | | y,Town or L Larks | | .e | | | | | 10d. Inside City Limits 1 ☐ Yes 2 No |
| | the N | Completed by Funeral Director | 10e. Street and Number | | | | | 10f. 2 | ip Code | | | 10g. C | itizen of What C | Country? |
| | h with | ai Di | 13938 Highl | and F | Road | | | | 21029 |) | | N | icarag | ua |
| | ems ? | Iner | 11. Marital Status | 12. | Was Decedent Armed Forces? | | S. 13. | Was Dec | edent of Hispan ecify Cuban, Me | ic Origin? (Sp exican, Puerto | ecify Yes or No Rican, etc.) | o- | 14. Race - Am Black, Wh | nerican Indian, iite, etc. |
| 36 | or it | y FL | 1 XNever Married 2 Ma 3 Widowed 4 Divorce | | 1 ☐ Yes 2 🔀 | No | | | 2 □ NoSp | ecify: | | | Specify: | White |
| Ö | hour tural | ed b | | ent's Educat | Year or Dates: | | 16a. Dece | edent's Us | ual Occupation | caragu | | 16b. | Kind of Busines | |
| 15 | n na | piet | (Specify only high Elementary/Secondary (0-12) | est grade c | ompleted) College (1-4or t | 5.4) | (Give | DO NOT | rork done during use retired) | most of worl | aing | | | |
| 21215-0036 | giene grene er tha | E O | Liententary/Secondary (0 12 | | 1 | | St | uder | - | | | <u> </u> | Colleg | e |
| Maryland | 5 <u>12 0</u> ≥ | To Be (| 17. Father's Name (First, Middle Miguel Ange | | gas | | | | | | e (First, Middle Game: | | n Sumame) | |
| Mary | d 2 should h and Men 7 ie marke traumatic | | 19a. Informant's Name/Relation Miquel A. Va | | | • | 1 | - | ss (Street and N | | | | | Zip Code) , Md 21029 |
| | 1 and Health Iom 27 other to | 10 | 20a. Method of Disposition | L gab, | - uciici | 20b. F | lace of Disp | osition (N | ame of | T | Date | 20c. l | ocation - City o | or Town, State |
| Baltimore, | ages ant of nt: If if | | 1 🛣 Burial 2 □ Cremation 4 □ Donation 5 □ Other | | noval from State | Ce | meter meter | inatory of | Mataga | lpa 1 | 1/24/0 | 5 M | atagal | pa licáragua |
| alti | permit. P Departme Importani any injuri | ĺ | 21. Signatur vel Funeral Service | // | | | | | | | | | | CE, P.A. |
| ä | e g ii ii g | | Mala Ox | well | <u> </u> | | C | 241 | Colum | bia B | lvd_Si | lve | | ng, Md20910 |
| 1 | | | 23a. Part1. Enter the disease, shock, or heart failure. Li | or complica st only one | tions that cause cause on each li | d the deat | h. Do not er | nter the m | ode of dying, sui | ch as cardiac | or respiratory | arrest, | <u>-</u> | Approximate Interval Between Onset and Death |
| Æ | Physician | - 0 | Immediate Cause (Final disease or condition | _ a. | Head | | inju | nu | 24 | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | | Due to (or as | a conseq | uen 🤄 of): | | | | | | | |
| | | <u>-</u> | Sequentially list conditions, | b | Due to (or as | a conseq | uanea of). | | | | | | | |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 【 . | | | | | | | | | | |
| o, | ate be executed hysician and he burial-transit | Exa | resulting in death) Last | Ü | Due to (or as | a conseq | uence of): | | | | | | | |
| 3760, | ate be nysici ne bu | ical | | d | | | | | | | | | | _ |
| ж 68 | eath certificat attending phy I for use as the | Physician/Med | IF FEMALE: | 220 | thus subserve | | | | | | | | | |
| Box | death co | ian/ | 23b. Was decedent pregnant in the past 12 months? | 230 | tf yes, outcome 1□Live birth 4□Pregnant a | 2 Feta | Ideath 3 | □Ectopic | pregnancy | | | | 23d. Date of d Month | elivery Day Year |
| P.O. | 0 0 | iysic | 1 □ Yes 2 □ No 9 □ Unknown | | 9 Unknown | t tillie or c | ea(ii) | _ Other (| specify | | | | | |
| | requires that the een signed by th nould be detache | by Pr | Part II. Other significant cond | itions contr | buting to death t | out not res | ulting in the | underlying | cause given in | Part I. | 23e. Did | tobacco | use contribute | to the cause of death? |
| Vital Records, | w requires been signi should be | ed b | | | | | | | | | 1 🗆 | Yes 2 | 2 ⊠ No 3□1 | Probably 4 Unknown |
| ဝွ | × C S Z | Completed | | | | | | | | | 24a. Wa | | 24b. Were | autopsy findings available completion of cause of |
| Ä | The ete has page | E O | | | | | | | | | | ormed? | death' | |
| /ita | Physicien: The la this certificete ha ral director, page 3 | Be (| 25. Was case referred to medi examiner? | | | | | | | Place of Dea | th (Check only | one) | | |
| of | Physical distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distribution of the standard distrib | 2 | 17€Yes 2 No 27. Manner of Death | HOS | spital: | | ER/Outpatie | | | ☐ Nursing H | ome 5 ☐ Res 28d. Describe | | 6 Other (Sp | pecify) |
| u o | After Une | ion | 1 □Natural 5 □ Pen | ding stigation | 28a. Date of Inju (Month, Da | | 21: 200 | | 28c. Injury at Work? 1 ☐ Yes | 2 X No | Deceas | ed d | nivmas 1 | entile - |
| Division of | il or Attendi after death. I Director: A d in by the fu | fica | 3 Suicide 6 □ Cou | - | 28e. Ptace of In | | | | _ | | 28f. Location | (Street a | nd Number or | Rural Route Number, |
| Dis | al or / after I Dire | Certification: | 4 Homicide | iiiiiou | building, e | tc. (Specii | Sad | | | | (City or To | own, Sta Cu ol | mills i | en River Fineway 2d. Howard Co. |
| | To the Hospital or Attention 24 hours after de To the Funerel Directo completely filled in by the | ledical (| (Check only 200) Medic | | r: On the basis | of examina | | | | | | | s) and manner | |
| | within 2 to the F | Med | 29b. Signature and title of certi | filar | and manner st | ated. | | - 2 | 29c. License nur | nber | | 29d. D | ate signed (Mo. | nth, Day, Year) |
| | ₹ <u>₹</u> 8 | | | 11/ | Shot | | | | O.C.M. | | | | - | 0, 2005 |
| | _ | | 30. Name and address of person | on who com | pleted cause of | death (Ites | n 23a) (Tyne | e. Print) | | | | | | |
| | 3 | | 5.12.1+0 | DCn | 400 | (| | | Street, | Balti | more, M | aryl | and 21 | 201 |
| 7 6 W | | ate | 31. Date filed (Month, Day, Ye. | 4 200 | 32. S gist | rar's Sign | ature | back | | | | | | |
| 1 | Regist | raf _ | 1404 1 | - ZUL | JJ Pake | Me - | N /50) | Barren Alberta | | | | | | |

05-*i*61*i* B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.27, perMF.G85012-16-05 TT State of Maryland / Department of Health and Mental Hygiene SHEILA M. WILLIAMS 1 - For Stete Registre 38467 Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Sheila M. Williams NOV. 2005 0220 /Medical 4b. City, Town, or Location of Death CHEVERLY 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES CITY HOSPITAL PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Sep. 12, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) 1 □ M 2 🛚 F Yrs 1972 33 Wash., 578-98-1065 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f ehow the Medical Exeminer must be notified at Director 1 XYes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5086 Just St., N.E. 20019 United States 'natural', or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after de Il Hygiene.
other than "natural", or Item 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if item 27 is marked other tha any injury or other traumatic event, Illas, once. 12th Lab Tech Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nellie Williams Thomas Dansby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1301 - 7th St., N.W. Wash., DC 20001 Nellie Kalu / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Harmony Memorial Park 11/21/2005 Landover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 Lewar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Asthmatic Attack /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consuluence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 2005 ll 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

5 Pending investigation

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? death?

2 No

25. Was case referred to medical examiner? XXYes 2 □ No 27 Manner of Death

1 XXIatural

2 Accident

3 Suicide

29a. Certifier

4 \(\text{Homicide}

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2. Proutpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

1 Yes

2 □ No

6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year) NOV. 11, 2005

of death (Item 23a) (Type, Print) 30. Name and

111 PENN STREET, BALTIMORE, MARYLAND 21201

State Registrar

31. Date filed (Month, Day, Year) NOV 2 1 2 1 2005



page 2 s

Be

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Medical Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completaly filled in by the funeral director.

| | | | For State Registrar | | State of N | Marylar | | artmen rtificate | | | | | Reg. No. | 005 | 3 | 8468 |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------|--------------------------|-------------------|----------------------|------------|---------------------------|-------------------------------------|----------------------|-----------------------|--------------------------------|
| | Physici | an | | Name (First, Middle, La | , | | | | | | | 2. Date of D Month | Day | Y. | ear | 3. Time of Death |
| | /Medic | cal | HAZEL | WILLIAN | | | | 41- 02- | | . 1 6: | (D 15 | Nov. | 10, | 2005 | | 9:35 a ^M |
| | Examir | ier | | me (If not institution, gi | | er) | | | | Location o | of Death | | | County of I | | |
| | Funeral | | 5. Social Secur | | Sex 7. | Age (In yrs. | last birthday) | Pocon If Under | 1 Year | If Under 2 | 24 Hrs. | 8. Date of B (Month, L | | | Birthpla | ce (State or Foreign |
| | Director | | 220-01 | 1-2098 | 1□M 2 점 F | 92 | Yrs. | Months | Days | Hours | Min. | Dec. | лау, үө <i>аг)</i> 1 , 19 | 12 | Mai | ryland |
| | pud * | | Usual Residen 10a. State | ce of Decedent | | 10c. Ci | ty, Town or Lo | ncation | | | | | | | 100 | d. Inside City Limits |
| | daryla f sho | 5 | MD | Worceste | er | | comoke | | | | | | | | 1.00 | 1 ☐ Yes 2 ŽÑo |
| | 28a- | Director | 10e. Street and | d Number | | | | 10f. Zip | Code | | | | 10g. Citi | zen of Wha | it Countr | y? |
| | h with | al D | 1738 (| Cypress Roa | ad | | | 21 | 851 | | | | | Ü | ISA | |
| | ems erra | Funeral | 11. Marital Star | tus | 12. Was Decede Armed Force | nt Ever in U | J.S. 13. | Was Deced | lent of H | ispanic Orig | gin? (Sper | cify Yes or N | 10- | 14. Race Black. \ | Americar White, et | |
| 36 | hours after death with the Maryland tural', or Items 23s or 28s-f show at Examinar must be notilited at | by Fu | _ | Married 2 Married red 4 Divorced | 1 Tes 2 f | ∆ No | | 1 ☐ Yes | - | Specify: | | , , | | Specify: | | |
| 21215-0036 | n 72 hours after death with the Manylan "natural", or ttems 23s or 28s-f show edissal Examinar must be natified at | | 3-2 WIGOW | 15. Decedent's E | Year or Date | 5. | 16a. Dece | dent's Usua | I Occup | ation | | | | nd of Busin | | |
| 215 | within 72 ene. than "nat | piet | | Specify only highest gr | rade completed) College (1-4c | or 54) | (Give | kind of wor DO NOT us | k done d | during most | of workin | 1g | | | | , |
| | 71 75 - | Completed | 10 | _ ' ' ' | Conlogo (1 40 | | Machin | e Opera | ator | | | | Gar | ment | Indu | ıstry |
| nd | o a a | Be | | ame (First, Middle, Las | | | | | | | | (First, Middl | e, Maiden | Sumame) | | |
| Maryland | D 9 2 0 | 5 | | D. Hancock | | | 105 14-16 | 4-1-1 | /Ch-==4 | | ne Ta | | | T Ct- | - 7:- 0 | . 4.1 |
| Ma | 0 0 0 | | | t's Name/Relationship C. Williams | | | | 383 | | | | Route Num | | | | 0.00 |
| | Heelth tem 27 other tr | | 20a. Method of | | (SOII) | 20b. i | ZZ4U Place of Dispo cemetery, crei | | | | | oke C | | cation - Cit | | n, State |
| MO | Ø 0 | | | I 2 □ Cremation 3 [tion 5 □ Other (Speci | | re l | cemetery, crei cst Bap | | | | 11/1 | 3/2004 | Poco | moke | City | - MD |
| Baltimore, | permit. Page Department of Important: If any injury or once. | | | of Funeral Service Lice | | ,2 44 | 22 | 2. Name an | d Addres | s of Facility | v | | | | CICI | , |
| m | 995 8 | | M | chal 11- | Dean | | 1 | 03 Li | ay r nder | Ave. | . Po | eral E comoké | City | v. MD | 218 | 51 |
| | | | shock, or | nter the disease, or con r heart failure. List only | nplications that cause on each | sed the dear | | | | | | | | . , | 11 | Approximate nterval Between |
| | Physician | | Immediate Ca | ndition | _a_do | me | MI | 4 | | | | | | | | Inset and Death |
| 1 | /Medical Examiner | | resutting in de | ain) | Due to (or | as a consec | quence of): | Silver of | . (| 1 | 0.10 | 0.0. | 1 47 | 7 | | |
| | | <u>-</u> | Sequentially list | st conditions, | b. Due to for | as a consec | uence of: | NON | | () | | nei | Pic | 1_ | | |
| | uted J ansit | Examiner | r any, leading cause. Enter leads (Diseas that initiated extends that initiated extends that initiated extends that initiated extends that initiated extends that initiated extends that initiated extends that initiated extends the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c | Underlying se or injury | , | | , | | | | | | | | | |
| o, | exectan and rial-tra | | resulting in de | | Due to (or | as a consec | quence of): | | | | , | | | | | |
| 8760, | cate be executed oblysician and the burial-transit | icai | | | _ d | | | | | | | | | | | |
| 9 | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: | | | | | | | | | | | | | |
| Вох | eath certific attending p I for use as I | ian/ | 23b. Was deci | edent pregnant st 12 months? | 23c. If yes, outcon | 2 Feta | al death 3 □ | Ectopic pr | | | | | 2 | 3d. Date of Month | , | ay Year |
| 0 | he de | ysic | | 2 (No) | 4□Pregnant 9□Unknowr | | 100 th 5 L | Other (sp. | өсіту) | | | | | | | |
| Δ. | that the dended by the s | | Part II. Other s | significant conditions | contributing to death | n but not res | sulting in the u | nderlying ca | ause give | en in Part I. | | 23e. Did | tobacco u | se contribu | te to the | cause of death? |
| rds | quires n sign uld be | d by | | | | | | | | | | 1 🗆 | Yes 2 | XN0 3[| Probab | ily 4 ∐Unknown |
| Records, | law requir as been si 2 should I | Completed | | | | | | | | | | 24a. Wa | | 24b. Wer | e autops | y findings available |
| R | 0 - 0 | mo | | | | | | | | | | per 1 Yes | ormed? 2 Z No | deat | h? | letion of cause of ☐ No |
| Vital | sician: Th certificete rector, pag | Bec | 25. Was case examiner? | referred to medical | | | | | | 26. Place | of Death | (Check ghiy | | | | |
| of V | Physician: this certific ral director, | 은 | 1 🗌 Yes | 2/XN0 | Hospital: 1 ☐ Inpa | | ER/Outpatier | | | 4 🗀 (40) | rsing Hom | | | Other (| Specify) | |
| | ding F h. After funera | ion | 27. Manner of 1≥Natura | al 5 ☐ Pending | | njury Day Ye <i>ar</i>) | 28b. Time of Injury | i 2 | 8c. Injun Work | ≀at <br Yes 2 □ N | | 8d. Describe | how injury | occurred | | |
| Division | deat deat ctor: y the | Certification; | 2 Accide 3 Suicid | e 6 ☐ Could not I | De 380 Blace of | Injury - At h | ome, farm, str | | | 193 2 1 | | 8f. Location | (Street and | d Number o | r Rural F | Route Number, |
| Θ | _ 0 | erti | 4 🗌 Homid | cide determined | building, | etc. (Speci | ly) | | , 000 | | | | wn, State) | | | |
| | he Hospital o in 24 hours eft he Funeral Di pletely filled in | | 29a. Certifier | Certifying P | hysician: To the be | st of my kno | wiedge, deati | occurred : | at the tim | ne, date and | place, a | nd due to the | cause(s) | and manne | r as stat | ed. |
| | To the Hos within 24 h To the Fur completely | edical | (Check on one) | // 2 Medical Exa | miner: On the basis and manner | of examina | uon and/or in | vestigation, | in my or | oinion, deat | n occurre | at the time | , date and | place, and | due to th | ne cause(s) |
| | To the within 2 To the complet | Σ | 29b. Signature | and affie of certifier | |) | | 29c | License | number | 70 | | 29d. Date | signed (N | fonth, Da | ly, Year) |
| | | | • | 1/ | 1 | | | | リン | 50 M | 12 | 5 | | 1110 |) [(| ١١ |
| 1 | 1 5 | | | address of person with | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | | - | .] | 71 — | NET - | 11054 | | | | |
| | Sta | te. | | hnson, MD | - 505 Ten | strar's Signa | reec, l | COOM | oke (| LITY, | | 1851 | | | | |
| | Registi | | | NOV 1 4 | 2005 | wa. | b A | nede | , | | | | | | | |

| | | | 1 - For State Registrar | State of Marylar | | artment of F rtificate of | | | iene g. No. 0 5 | 38469 |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------|----------------------------------------------------|-------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, La: | | h - 1 | | | 2. Date of Deat Month | Day Y | 3. Time of Death |
| | /Medic | cal | Walter Reg | | neı | 4h City Tourn | r Location of Dea | November | 4c. County of | |
| | Examir | ner | 4a. Facility Name (If not institution, given St. Mary's Nursir | | | Leonard | | un | St. Ma | |
| | Funeral | 7 | 5. Social Security Number 6. S | ex 7. Age (In yrs. | last birthday) | If Under 1 Year | If Under 24 Hr Hours Mir | | | Birthplace (State or Foreign Country) |
| | Director | | 5/9-03-9054 | X ¹ M ² □ F 90 | Yrs. | Months Days | Hours IVIII | Sept. 1 | 8, 1915 | Pennsylvania |
| | and and | | Usual Residence of Decedent 10a. State 10b. County | 10c. Ci | ty, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Mary -1 • ho | ţ | MD St. Mar | rv's | | Leonard | ltown | | | 1 X Yes 2 □ No |
| | th the | Director | 10e. Street and Number | - | | 10f. Zip Code | | 10 | Og. Citizen of Wh | at Country? |
| | death with the Maryland ome 23a or 28e-f ehow if court be notified at | | 22680 Cedar Lane | | | | 0650 | | USA | |
| 20 | be filed within 72 hours after death with the Marylan Ital Hygiene. id other then "natural", or Iteme 23a or 28e-1 ehow event, Ita Medical Exacting must be rollified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | Was Decedent of H f Yes, specify Cubi 1 ☐ Yes 2🂢 No | lispanic Origin? (an, Mexican, Pue Specify: | Specify Yes or No- irto Rican, etc.) | | American Indian, White, etc. white |
| 2-003a | 2 hou | | 15. Decedent's Ed | ducation | 16a. Dece | dent's Usual Occup | pation | | 16b. Kind of Busin | |
| 7 | within 7 ene. then "n | Completed | (Specify only highest gra | College (1-4or 5+) | life. | kind of work done DO NOT use retired | during most of wi d) | orking | | |
| A | filed wi Hygien ther th | | 8 | | banqı | et waite | | Cina Middle A | cateri | ng |
| yland | ild be fi lental H ked otl | Be | 17. Father's Name (First, Middle, Last) | | -1 | | | ame (First, Middle, M | | ili on I |
| | ss 1 and 2 should be of Health and Mental litem 27 le marked or r other treumatic eve | မ | Theodore 19a. Informant's Name/Relationship (| Wuensche | | ng Address (Street | Margare | et M. Rural Route Number. | | Wuerl ate, Zip Code) |
| Z | alth a | | Scott Paterson, r | ıephew | 2225 | Garrity | Rd., St. | . Leobnard | i, MD 20 | 685 |
| e G | of Her | | 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ | Removal from State | Place of Dispo | sition (Name of matory or other place | ce) | Date 2 | 20c. Location - Ci | ty or Town, State |
| baltimo | Pagiment tant: h | | 4 Donation 5 Other (Specif | y) Met | | tan Crem | | I-08-05 | Alexand | ria, VA |
| | permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once. | | 21. Signature of Fugeral Service Licer | 1500 | | . Name and Addre | | | - 1 | 20726 |
| | | _ | 23a. Part1. Enter the disease, or com | plications that caused the dea | | | | ome, P.A., | | Approximate |
| | Physician | | shock, or heart failure. List only Immediate Cause (Final disease or condition | one cause on each line. | PV | D | | | | Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consec | uence of): | nyclitic | 3 | | | |
| × | p = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consec | | | | | | |
| | icate be executed physician and s the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consec | Tuence of): | | | | | |
| 8/60, | be en sician buria | calE | | 7 M | quantes on. | | | | | |
| 20 | ifficate g phys as the | D | | | | | | | | |
| X Q Q | th certii ending r use a | an/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta | | Ectopic pregnancy | , | | 23d. Date of | |
| _ | w requires that the death certif been signed by the attending should be detached for use a | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Pregnant at time of o | | Other (specify) | ' | | Month | Day Year |
| Į. | that the | | Part II. Other significant conditions of | ontributing to death but not re- | sulting in the u | nderlying cause giv | en in Part I. | 23e. Did tob | acco use contribu | ute to the cause of death? |
| ecords, | requires that the leen signed by th hould be detache | ed by | | | | | | 1 □ Ye | s 2□No 3 | Probably 4 Unknown |
| င္တ | law rec as bee 2 shou | Completed | | | | | | 24a. Was ar | 24b. We | re autopsy findings available |
| <u>r</u> | The ate his page | Eo | | | | | | autopsy perform 1 Yes 2 | ned? dea | or to completion of cause of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of the later of th |
| Vitai H | ysicien: Th is certificate director, pag | Be | 25. Was case referred to medical examiner? | Lie and als | | 011 | | eath (Check only one | | |
| 0 | Physic this cral dire | - To | 1 ☐ Yes 2X No 27. Manner of Death | Hospital: 1 Inpatient 2 28a. Date of Injury | ER/Outpatien | | 4 X Nursing | Home 5 Reside | | |
| 0 | Attending Physicien: r death. ector: After this certific by the funeral director, | tion | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day Year) | Injury | Wor | k? Yes 2∐No | 200. Describe no | w injury occurred | |
| DIVISION | of or Attendi after death. Director: A d in by the fu | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | | ome, farm, str | eet, factory, office | | 28f. Location (Str City or Town | eet and Number , State) | or Rural Route Number. |
| | To the Hospitel or Attandi within 24 hours after death To the Funeral Director: A completely filled in by the ft | edical C | 29a. Certifier 1 Certifying Ph (Check only one) 2 Madical Example | nysician: To the best of my kno niner: On the basis of examina and manner stated. | owledge, death ation and/or in | n occurred at the tirvestigation, in my o | me, date and place pinion, death occ | ce, and due to the ca curred at the time, da | use(s) and mann ite and place, and | er as stated. I due to the cause(s) |
| | To the within To the comp | Me | 29b. Signature and title of certifier | 0 | | 29c. Licens | | | | Month, Day, Year) |
|) | | |) Den | ih | | D | 4706 | 00 | 11.7. | 05 |
| | 3 | | 30. Name and address of person who | | | - | Storm 35 | D 206E0 | | |
| 10 | Sta | ate 1 | A.D. Shah, M.D., 31. Date filed (Month, Day, Year) | | | , Leonard | ICOWII, M | D 20650 | | |
| | Pogiet | | ו אמע ו | 8 2005 | Lo | 1 40 | | | | |

| KTOR -077 | IA R. W 94 | IL: | SON Unpend i | Please item#23a,2 | Type or Pri perME (851 State of M | n t in B 1/19/0 arylan | llack in 6 TT d / Depa | delibl artmei | e Ink. nt of H | Ens lealth | ure All and M | Copies | s Are ygien | Legit e | le. | |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------|-------------------------------------|---------------------------------------|-------------------------|------------------------------------|----------------------|------------------|-------------------------------|-----------------------|-------------------|------------|--------------------------------------------------|
| J | | | For State Registrar | | | | Ce | rtifica | te of L | Deatl | h | | Reg. N | 200 | 5 | 38470 |
| 100 | Physici | an. | 1. Decedent's Name | | | | | | | | | 2. Date of D Month | eath Da | ay | Year | 3. Time of Death |
| 100 | /Medic | | | a R. A. | | | | | | | | Novemb | | | 005 | 1:25 a. [™] |
| | Examir | er | | _ | ve street and number) Hospital Ce | | | | r, Town, or | _ | n of Death | | | C. County o | | |
| 10 | Eurovol | | 5. Social Security N | | | | ast birthday) | If Unde | hever | If Unde | er 24 Hrs. | 8. Date of B | irth | | | orge's place (State or Foreign |
| 3 | Funeral Director | | 219-71-6 Usual Residence of | 19/3 | 1□M 210 F | | Yrs. | Months 7 | Days | Hours | Min. | 3/21/ | 2005 | 1 | Coul | |
| | /land | | 10a. State | 10b. County | | 10c. City | , Town or Lo | cation | | | | | | | 1 | 0d. Inside City Limits |
| | Man Be-f sh | ţċ | Maryland | Montgom | ery | Gai | thers | burg | | | | | | | | 1 ☐ Yes 2X No |
| | or 28 | Directo | 10e. Street and Nur | mber | | | | 10f. Z | ip Code | | | | 10g. C | itizen of W | hat Cour | ntry? |
| | ath w | rai | 9615 Mar | athon Te | rrace Apt | | | | 20878 | | | | 1 | USA | | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Maryland Examination and the motified at once. | by Funerai | 11. Marital Status 1 □XNever Marri 3 □ Widowed | ied 2 Married | 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | , | | | edent of Hi ecify Cuba 25xNo | | | cify Yes or N Rican, etc.) | 0- | | , White, | |
| 8 | hour tural | ed b | 3 | 15. Decedent's E | | | 16a. Dece | dent's Usi | ial Occupa | ation | | _ | 16h k | Cind of Bus | | ack |
| altimore, Maryland 21215-0036 | within 72 iene. than "na | Completed | (Specification) | cify only highest g | | 5+) | (Give | kind of w DO NOT i | | durina mo | ost of workir | ng | 100.1 | And or Bus | 111633/11 | dustry |
| 0 | Hygi other | BeC | 17. Father's Name | (First, Middle, Las | t) | | | | | 18. Mot | her's Name | (First, Middle | e, Maidei | n Sumame |) | |
| <u>a</u> | Ald be Alenta rked tlc ev | To B | Brando | n Wilson | | | | | | L | atika | Hill | | | | |
| ary | and A | | 19a. Informant's Na | ame/Relationship | (Type, Print) | | 19b. Mailin | ng Addres | s (Street a | and Num | ber or Rura | Route Numb | ber, City | or Town, S | tate, Zip | Code) |
| ≥. | and and malth m 27 | | Melva Hi | | ndmother | | 9615 | Mara | thon | Ter | | | | | | irg MD 2087 |
| imore | Pages 1 nent of H ant: If ite | | | | □Removal from State | Cé | ace of Dispo emetery, crei e of | natory or | other plac | | 11/25 | ate /2005 | | ocation - C | • | ng, MD |
| Balt | eparti oporti ny inj | | 21. Signature of Fu | ineral Service Lice | ensee | 4 | 22 | 2. Name a | ind Addres | s of Fac | Hin | es-Rin | aldi | Fune | ral | Home |
| | Physician /Medical Examiner | | shock, or hea Immediate Cause (disease or condition resulting in death) | rt failure. List only (Final on | pplications that caused one cause on each line. a. Sudden Due to (or as | _{ne.} Infant | Death S | er the mo | de of dying | g, such a | s cardiac o | r respiratory | S11V arrest, | er Sp | ring | Approximate Interval Between Onset and Death |
| 3760, | licate be executed physician and sthe burial-transit | ical Examiner | Sequentially list confidence and life and life and life ause. Enter Unde Cause (Disease or that initiated events resulting in death) I | injury | Due to (or as Due to (or as | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 687 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit | Physician/Medica | IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ Unknown | months? | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal | death 3 | Ectopic p | pregnancy pecify) | | | | | 23d. Date Mont | | ory Day Year |
| ط ا | s that ned by a deta | by Ph | Part II. Other signif | icant conditions | contributing to death b | ut not resu | Ilting in the u | nderlying | cause give | n in Parl | : 1. | 23e. Did | tobacco | use contrib | oute to th | e cause of death? |
| rds | w require been sig should b | | | | | | | | | | | 1 🗆 | Yes 2 | No 3 | Prob | ably 4 □Unknown |
| Reco | Physician: The law re this certificate has bee at director, page 2 sho | Completed | | | | | | | | | | 24a. Was auto perf | | de | ath? | psy findings available πpletion of cause of 2 Νο |
| ita | ian: ortifica ctor. p | Be C | 25. Was case reference examiner? | red to medical | | | | | | 26. Plac | e of Death | (Check only | | <u> </u> | | |
| <u>></u> | hysic his ce I dire | 2 | XXYes 2□ | No | Hospital: 1 ☐ Inpatie | | ER/Outpatier | | | 4 🗆 1 | lursing Hom | ne 5⊡Res | dence | 6 Other | (Specify | 1) |
| sion o | al or Attending P after death. I Director: After to d in by the funera | Certification: | 27. Manner of Deati | h 5 Pending investigation 6 Could not less | | | 28b. Time of Injury | М | | at ? Yes 2 | | 8d. Describe | how inju | iry occurre | d | |
| Divis | To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by i | | 3 ☐ Suicide 4 ☐ Homicide | determined | building, et | c. (Specify | | | | | | City or To | wn, State | θ) | | l Route Number, |
| | the Hosp in 24 hou the Fune ipletely fil | ledical | 29a. Certifier (Check only one) | 2 X Medical Exa | hysician: To the best miner: On the basis o and manner sta | f examinat | wledge, deatl ion and/or in | vestigation | n, in my op | pinion, de | ath occurre | nd due to the | , date an | d place, an | d due to | the cause(s) |
| | To with To Corr | Σ | 29b. Signature and | un'a | Onica - | Poll | Dere | 0 | OCM | Ξ | | | Nove | | 19, | 2005 |
| _ | | | 30 Name and addr | ess of person who | completed cause of d | death (Item | 23а) (Туре, | Print) 1 | 11 Pe | enn S | Street | : Balt | imoi | re, M | ary1 | and 21201 |
| | Sta Registr | | 31. Date filed (Mon. | th, Day, Year) | 32 Registr | ar's Signat | nte | ade |) | | | | | | | |

| | | | For State Registrar | State of M | laryland / De | oartment e <i>rtificate</i> | | | nd Me | | ne 2.005 | 38471 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------------------|----------------------------------|----------------------------------------------------------------|
| | Physici /Medic | | Decedent's Name (First, Middle, Last Paul Eugene Wil | | | | | | | Date of Death Month | Day Y | 3. Time of Death |
| | Examir | | 4a. Facility Name (If not institution, give 144 Southern Oa | street and number K Drive | 7) | | erst | | | -vovenibe | 4c. County of Washin | Death ngton County |
| | Funeral Director | | 5. Social Security Number 6. S. 214-32-2593 Usual Residence of Decedent | 7. A | ge (In yrs. last birthda 72 Yrs. | | | Under 24 Hours | Min. | Date of Birth (Month, Day, Y | | B. Birthplace (State or Foreign Country) Maryland |
| | show show | or | 10a. State 10b. County Maryland Washing | oton | 10c. City, Town or | Location erstown | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | r 28e-f | Director | 10e. Street and Number | JCO11 | liag | 10f. Zip C | | | | 100 | . Citizen of Wh | |
| | 23a o | a D | 144 Southern Oal | k Drive | | | | 21740 |) · | | U.S.A | ١. |
| 9800 | be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neture!, or items 23a or 28e-1 show event, the Medical Era: it without the trailing at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Deceden Armed Forces 1 Tyes 2X If Yes, Give Year or Dates | ?]No | I. Was Deceder If Yes, specify | | anic Origin Mexican, P Specify: | ? (Specifi Puerto Ric | y Yes or No- an, etc.) | | American Indian, White, etc. White |
| Maryland 21215-0036 | within 72 h ene. then "netu | Completed | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) | | · 5+) (Gi | edent's Usual of work DO NOT use | done duri retired) | n ing most of | f working | 16 | b. Kind of Busin | ness/industry ft Mfg. |
| d 2 | e filed of Hygie other t | Be Co | 17. Father's Name (First, Middle, Last) | | | Machini | | . Mother's | Name (F | irst, Middle, Ma | | it Mig. |
| ylar | | To B | Paul R. Williams | | | | | | | or Will | | |
| Mar | nd 2 shoulth and 27 is m | | 19a. Informant's Name/Relationship (7 JoAnn Williams | урө, Print) (Wife) | | | | | | oute Number, C | | ate, Zip Code) aryland 21740 |
| Baltimore, | permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once. | | 20a. Method of Disposition 1 Strial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Removal from State | 20b. Place of Dis | | of er place) | | Date -7-0 | 20 | c. Location - Ci | ty or Town, State 11e Maryland |
| Balti | permit. Departm Importal any inju | | 21. Signifure of Juneral Service Licen | | . 1 | 22. Name and | Address o | f Facility | Doug. | las A. | Fiery F | uneral Home aryland 21742 |
| | Physician | 0.1 | 23a. Part1. Enter the disease, or com- shock, or heart farlure. List only Immediate Cause (Final disease or condition resulting in death) | lications that cause one cause on each a. | ed the death. Do not e line. VOREATIC | cancer the mode of | of dying, s | uch as car | rdiac or re | espiratory arrest | , | Approximate Interval Between Onset and Death MWTHS |
| | /Medical Examiner | | | Due to (or a | s a consequence of): | | | | | | | |
| | cuted nd ransit | Examiner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | s a consequence of): | | | | | | | |
| 8760, | icate be executed physician and the burial-transit | dical Ex | resulting in death) Last | Due to (or as | s a consequence of): | | | | | | | |
| .O. Box 6 | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | 2 Fetal death 3 | □Ectopic preg □ Other (spec | | | | | 23d. Date of Month | • |
| <u>α</u> | w requires that been signed by should be deta | by | Part II. Other significant conditions co | entributing to death | but not resulting in the | underlying cau | se given ii | n Part I. | | 23e. Did tobac | -4" | ute to the cause of death? Probably 4 Unknown |
| Il Records, | | Completed | | | | | | | _ | 24a. Was an autopsy performed | prio dea | re autopsy findings available in to completion of cause of th? |
| Vital | sicien: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | Othor | | | heck only one) | | |
| Division of | this al di | ıtlon: To | 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Inj (Month, Da | The second second | | Injury at Work? | 4 Nursin | | 5 Residence escribe how | e 6 Other (injury occurred | (Specify) |
| Divis | To the Hospitet or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Inbuilding, e | njury - At home, farm, s tc. <i>(Specify)</i> | treet, factory, o | ffice | | 28f. | Location (Stree City or Town, S | | or Rural Route Number, |
| | To the Hospitel or within 24 hours after To the Funerel Dir completely filled in | Medical (| 29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam | rsician: To the best iner: On the basis and manner s | t of my knowledge, dea of examination and/or tated. | ith occurred at nvestigation, in | the time, o my opinio | date and pl on, death o | lace, and occurred a | due to the caus it the time, date | e(s) and manne and place, and | er as stated. I due to the cause(s) |
| | To t To t | 2 | 29b. Signature of title of certifier | Conner | MA | | D3 | 17/1 | , | | 11/10 | Month, Day, Year) |
| śΗ | -15 | | 30. Name and address of person who can be in the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of the interpretation of | ompleted cause of | death (Item 23a) (Type M & 50 f | e, Print) W. SEA | 16NT) | 4 57 | · F. | reserie | K M | 21701 |
| | Sta R egistr | - | 31. Date filed (Month, Day, Year) NOV 1 4 2 | 32. Regist | rar's Signature | perte | | | | | | 140 |

State of Maryland / Department of Health and Mental Hygiene 38472 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 **Physician** Month WHITE 7:37 NOVEMBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BAUTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 58 Yrs. 8. Date of Birth (Month, Day, Year)
May 22, 1 If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days Min. Hours 1 ☐ M 2 ☐ F Director ۷á. 1947 233 76 3276 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Garrett 0akland 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10th St. 21550 USA 212 N. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced *natural*, White or than "natura Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaking other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: It item 27 is marked oth any july or other traumatic svent 2008. Be 18. Mother's Name (First, Middle, Maiden Sumame) Vilda D. Lantz Roy L. Lewis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oakland, MD 21550 212 N. 10th St. Oakley C. White Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 11- 8-05 Garrett Memorial Oakland, MD 21. Signature at Funeral Service Licens 22. Name and Address of Facility Burdock-Durst Funeral Home Oakland, MD 21550 212 N. 2nd St. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ABDOMINAL TUMOR **Physician** MOUTHS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of deliver 3 Ectopic pregnancy ō Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy performed? certificate Division of Vital 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🖾 Inpatient in by the funeral dir 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L To the Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I maria Carmila n. trosales, medical doctor P18614 NOVEMBER 5,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV - 7

2005

32. Registrar's Signature

MARCIA CARCHELA N. ROSALES, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE ST. BALTIMORE MD 21287

DHMH 17 Rev 1/2001

Registrar

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| | | | 1 _ State | | it of Health and Me e of Death | | 21115 | 38474 |
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| | Div. | | 1. Decedent's Name (First, Middle, Last) | Ochimoat | | Reg. i | Day Year | 3. Time of Death |
| | Physic /Med | ical | 4a. Facility Name (If not institution, give street and number) | | Town, or Location of Death | brember | 8 2005 | 10/73 |
| | Exam | iner | PENINSULA SUADANAS MEDICAL | 111 | SAUISHUM | | 4c. County of Death | |
| | Funera Directo | | | S. last birthday) If Under Months | Days Hours Min. | B. Date of Birth (Month, Day, Yea | ar) 9. Birth | nplece (State or Foreign untry) |
| | | | Usual Residence of Decedent | | | July 14, 1 | 1921 | |
| | Maryla f ehov | Į. | 10a. State 10b Sounty 10e-of | Tincess | L 22 | | | 10d. Inside City Limits 1 ☐ Yes 2 🔼 No |
| | or 28e | Oirec | 10e. Street and Number | 10f. Zip | | 10g. (| Citizen of What Cou | untry? |
| | atter death with the Marylan or Iteme 23e or 28e-f show | Funeral Director | 11, Marital Status 12. Was Decedent Ever in | | 21853 | ify Yes or No- | 14. Race - Amer | A nican Indian |
| 1, como | within 72 hours atter death with the Maryland with 72 hours atter death with the Maryland ane. than 'natural', or iteme 23s or 28e-f show item Marilan Exerciting transities and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and items at a second and | þ | 1 Never Married 2 Married 1 Process? 1 Never Married 2 Married 1 Process? 1 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process 2 Process | If Yes, spec | dent of Hispanic Origin? (Spec city Cuban, Mexican, Puerto Ri 2 No Specify: | can, etc.) | Black, White | |
| 4 1 | in 72 h | piete | 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usua (Give kind of wo life. DO NOT us | rk done during most of working | | . Kind of Business/I | 7 1 |
| 11: | filed withi Hygiene. other ther | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | Lab | ORER | | | Soup Co. |
| Va Wil | permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatic event, ILE Manone. | To Be | 17. Father's Name (First, Middle, Last) Edgar Williams | | 18. Mother's Name (| A B | eckett | |
| | 1 and 2 sh Heelth and tem 27 is m | | Soft J. Benneth - Son | 1500 Nd | (Street and Number or Aural) | ^ | sy or Town, State, Zi | p Code) 1 |
| ∂ Saltimore | Pages 1 a lent of Hee nt: If item ry or othe | | | . Place of Disposition (Nan cemetery, crematory or o | ne of Da | te 20c. | Location - City or T | |
| i. | nit. Pa artmen ortant: injury | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | Charles Ce | | | hance | MD |
| a | permit. Departm importa eny inju | | Halling & Word 8h | 306 a | nd Address of Facility Only E. Ward 1 9 Hampden A | runeral the | ss Anne | ND 21853 |
| | | | 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final | eath. Do not enter the mod | e of dying, such as cardiac or | respiratory arrest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) Due to (or as a conse | | CHLOIOVAS | CHICAR | 115815 | YEAR S |
| | Examiner | Į, | Sequentially list conditions, b. Due to (or as a conse | 0 | | | | |
| | outed of an slt | Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | эдцепсе от: | | | | |
| 9 | icate be executed physicien and s the buriat-transit | | resulting in death) Last Due to (or as a conse | equence of): | | | | |
| 68760 | phy: | edicai | d | | | | | |
| O Box | C a C . | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 monubs? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of 9 ☐ Unknown | etal death 3 Ectopic pr | | | 23d. Date of deliv Month | very Day Year |
| 0 | es that the igned by t be detach | by Ph | Part II. Other significant conditions contributing to death but not re | esulting in the underlying c | ause given in Part I. | 23e. Did tobacco | o use contribute lo t | the cause of death? |
| ord. | v require been sig should b | | | | | 1 🗆 Yes | 2 □ No 3 □ Pro | bably 4 🖭 Unknown |
| Division of Vital Becords | The law ate has b page 2 s | Completed | | | | 24a. Was an autopsy performed? | death? | opsy findings available ompletion of cause of |
| Vita | sicien: certifica irector, p | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 | | 26. Place of Death | | | |
| Ď | ding Phys h. After this funeral di | on: To | 1 Yes 2 No 1 Inpatient 2 | ER/Outpatient 3☐ DO 28b. Time of Injury | | d. Describe how in | 6 ☐Other (Special jury occurred | <u>(y)</u> |
| isi | Attendia death. ctor: A | icatic | 2 Accident investigation 3 Suicide 6 Could not be | home, farm, street, factory | 1 ☐ Yes 2 ☐ No | Loggian (Ctura | | |
| į. | tai or A s after ai Dire | Certification: | 4 Homicide determined building, etc. (Spec | oify) | , once | City or Town, Sta | and Number or Run ate) | ai Houte Number, |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t | edicai | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated. | nowledge, death occurred a nation and/or investigation, | at the time, date and place, and in my opinion, death occurred | d due to the cause(at the time, date a | (s) and manner as s ind place, and due t | stated. to the cause(s) |
| | To t To t | Σ | 29b. Signature and title of certifier | | License number | 29d. D | Date signed (Month. | |
| | | | 30. Name and addr s of person impleted cause of death (ite | | 00062916 | | 11,08, | 2005 |
| | | _ | STETLAND GURENARZ 141 | 5 SQUITH E | MIVISION SUIT | EB SA | assan n | ann 2180 y |
| | St Regis | ate trar | 31. Date filed (Month, Day, Year) NOV 1 0 200 | we & Sa | arte | | | |

ORIGINAL

| | | | For State Registrar | State of Ma | ryland / Dep | | Health and | Mental Hygie | 2 005 | 38475 |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|---------------------------------------------------|-----------------------------------------------|
| E. | Physici | | Decedent's Name (First, Middle Helen | , _{Last)} Elizabeth | Wempe | | | 2. Date of Death Month | Day Year | 3. Time of Death |
| 100 | /Medic Examir | | 4a. Facility Name (If not institution, | | vvenipe | 4b. City, Town, o | or Location of Dear | November | 4c. County of Deat | |
| 4. | Funeral | | Memorial 5. Social Security Number | 4014 005 | (In yrs. last birthda | | Der Curl If Under 24 Hrs Hours Min | B. Date of Birth | Allega | 1) pplace (State or Foreign |
| * | Director | | 219-14-7077 Usual Residence of Decedent | 00 | | | | Dec 22, 1 | 924 | MB |
| | Marylar F show | tor | MD 10b. County Alleg | | 10c. City, Town or Cum | berland | | | | 10d. In side City Limits 1X☐ Yes 2☐ No |
| | with the | I Direc | 10e. Street and Number 601 E. Oldtown | Road | | 10f. Zip Code | 21502 | 10g. | Citizen of What Co | untry? |
| 036 | be filed within 72 hours after death with the Maryland ital Hygiene. I have a seen than "natural", or Items 23s or 28s-f show event, the Medical Exercities resulted at | by Funeral Director | 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | 12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | ver in U.S. 13 | Was Decedent of H If Yes, specify Cub | | Specify Yes or No- to Rican, etc.) | 14. Race - Amer Black, White Specify: White | , etc. |
| 215-0 | nin 72 ho n "natur Medical | Completed | 15. Decedent (Specify only highes | t grade completed) | (Giv | edent's Usual Occup re kind of work done DO NOT use retire | during most of wo | rking 16b. | Kind of Business/I | ndustry |
| 212 | e filed within at Hygiene. other than " | Com | Elementary/Secondary (0-12) | College (1-4or 5+ | labore | er | | Tire | e Compan | У |
| Baltimore, Maryland 21215-0036 | should be fill and Mental Hy marked oth imatic event | To Be | 17. Father's Name (First, Middle, L Joseph U. We | empe | | | Mary A | me (First, Middle, Maid nn Brinker V | Vempe | |
| , Mar | and 2 shealth and 27 is m | | Joann Lease | nip (Type, Print) niece | ^{19b. Ma} 207 | ling Address (Street Wempe L | and Number or Ri Prive | ural Route Number, Cit Cumberl | or Town, State, Z and ME | 21502 |
| more | Sages 1: ent of He nt: If iten ny or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | 20b. Place of Disposers, cometery, con | position (Name of ematory or other pla Demetery | ce) | Date 20c. | Location - City or 1 umberland | |
| Balti | permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic e ance. | | 21. Signature of Funeral Service L | | 111 | 22. Narscal per | | ome, PA | | |
| | \$ to | | 23a. Part1 Enter the disease, or shock, or heart failure. List of | complications that caused the | he death. Do not e | | | e: Cumberland c or respiratory arrest, | 1, IVID 2 1502 | Approximate |
| | Physician | | Immediate Cause (Final disease or condition | Seps | is | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (on as a | consequence of): | - | | | | , week |
| | | ner | Sequentially list conditions, | b. Que to (or as a | еогледиалов of): | | | | | |
| • | xecuted and al-transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as a | consequence of): | | | | | |
| 8760, | icate be executed physician and s the burial-transit | icai | | d | . , , | | | | | |
| P.O. Box 6 | Attending Phyaician: The law requires that the death certificate be executed rideath. c death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burral-transit. | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown | Fetal death 3 | □Ectopic pregnanc; □ Other (specify) _ | , | | 23d. Date of deliving Month | ery Day Year |
| | quires that n signed b uld be deta | by | Part II. Other significant condition Huzer tension | | not resulting in the | underlying cause giv | en in Part I. | | | the cause of death? |
| l Records, | The law requir ate has been si page 2 should I | Completed | Leukemoid | Reaction | | | | 24a. Was an autopsy performed? | prior to co death? | opsy findings available impletion of cause of |
| /ita | ician: Sertific Sector. | Be | 25. Was case referred to medical examiner? | I to a section | | | | ath (Check only one) | | |
| Division of Vital | Attending Phyaician: The Isr death. rector: After this certificate haby the funeral director, page | ation: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | | | of 28c. Injur Wor | 4 Nursing F | fome 5 Residence 28d. Describe how in | | (y) |
| Divis | of or Attend after death Director: / d in by the f | Certification: | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | | y - At home, farm, s (Specify) | treet, factory, office | | 28f. Location (Street and City or Town, Sta | and Number or Rur te) | al Route Number, |
| | To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Medical C | 29a. Certifier (Check only one) 1 Certifying 2 Medical E | Physician: To the best of examiner: On the basis of examiner state | xamination and/or i | th occurred at the tin nvestigation, in my o | ne, date and place pinion, death occu | , and due to the cause rred at the time, date a | s) and manner as s nd place, and due t | stated. o the cause(s) |
| | | Me | 29b. Signature and title of certifier | -1 111 | | 29c. Licens | e number | 29d. D | ate signed (Month, | Day, Year) |
| | 3 | | > Huma &1 | and MI) | | DU | 1634h | Nov | ember 1 | 4 ,2005 |
| | nes | | 30. Name and address of person w | 1 000 | | | C . \ _ | α. Λ \ | 7 / | 20 |
| 44 | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar' | S Signature | AVENUE, | suite 2 | ou, Cumbe | Cland, M | D.9120.7 |
| | Registr | _ | NOV 1 4 200 | Medie . | 15 April | les . | | | | |

State of Maryland / Department of Health and Mental Hygieme 0 05 1 - State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20° 2005° Ruth Ann Young Nov. 9:15 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenwald Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 🗓 F 157-07-2313 86 June 12, 1919 **Director** Pennsylvania Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mantal Hygiene.
shall it least 23 is marked other than 'natural', or Itams 23a or 28a-f show and it if Itams to other traumatic event, the Madical Examine must be notified at MD Baltimore Towson 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road U.S.A. 21286 Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White If Yes, Give Year or Dates: WW II 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James McKinley Young Annie I. Bowser 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Bryan Young/Nephew 204 St. Charles Way, York, PA 17402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State Date permit. Pages Department of Important: If II any injury or o 1 X Burial 2 ☐ Cremation 3 X Removal from State Nov. New Freedom Cemetery New Freedom, PA 2005 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licensee 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNITUMUNI disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner BLZHN17811 のほクロハリアの Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner nding physician and use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pendina I Director: A investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certified 027838 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SISCAMP MBMIIRA: LIAITHCUM 70 SHAVENS . Registrar's Signature State Registrar

| | | | 1 - For State Registrer | State of M | larylan | d / Depa | artmer tifica | nt of H te of L | ealth an Death | d Menta | al Hygie | HARM AND AND |)5 3 | 384 | 77 |
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| > | Physici | | 1. Decedent's Name (First, Middle, La Isiah Carlos Zam | , | tos | | | | | Mo | ate of Death onth ovembe: | Day | Year | 3. Time of 5:45 | Death a M |
| T | /Medic Examir | | 4a. Facility Name (If not institution, giv | | .) | | | | Location of D | eath | o vembe. | | ty of Death | 5:45 | |
| | Funeral Director | | Holy Cross Hosp 5. Social Security Number 6. S | | | last birthday) Yrs. | | r 1 Year | | Hrs. 8. Da | ite of Birth conth, Day, Ye | ar) | 9. Birthp | lace (State o | or Foreign |
| | ט | | None Usuat Residence of Decedent 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | 3 Nov | vember | 4, 4 | | arylar Od. Inside Ci | |
| | ith the Ma or 28a-f | Director | Maryland Montgo 10e. Street and Number | mery | Sil | ver Sp | | o Code | | | 10g. | Citizen of | f What Coun | 1 ☐ Yes | 2 🔀 No |
| 36 | permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be notified at ance. | y Funeral Director | 9049 Manchester R 11. Marital Status 1X Never Married 2 Married | 12. Was Deceden Armed Forces 1 □ Yes, 21% If Yes, Give | ? | 1 | Vas Dece f Yes, spe | | spanic Originî n, Mexican, Pi | | es or No- etc.) | 14. Ra Bla | JSA ace - Americ ack, White, e | etc. | |
| 21215-0036 | ithin 72 hours ne. nen "natural" e Mudical Ex | Completed by | 3 Widowed 4 Divorced 15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12) | | | 16a. Deced | lent's Usu | al Occupa | tion uring most of | | | | Business/Ind | | |
| Maryland 21 | uld be fited w fental Hygier rked other ti tic event, thi | To Be Cor | 0 17. Father's Name (First, Middle, Last, Roberto Santos | | | Ne | ver V | Vorke | 18. Mother's | | Middle, Maid | len Suma | applica nme) | able | |
| , Mary | and 2 should and Min 27 is mail | | 19a. Informant's Name/Relationship (Amy Zambrana/ Mo | | | 9049 | Mano | chest | | | e Number, Cit Lver Sp | | | | 20901 |
| Baltimore, | tant: If the | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | () | 0 | lace of Disposemetery, crem | atory or o | other place Cemete | ry No | vembe 2005 | r 9 Si | lver | - City or To | | rylan |
| Bai | Depar Impor any in | | 21. Signature of Funeral Service Licer 23a. Part1. Exter the disease, or com | Jobby | | 50 | 00 Ur | iver | sity B | lvd, W | neral H I, Silv | ome er S | Inc. pring, | | |
| 8760, | Physician /Medical Examiner bhysician and bhysician and physician and physician and street in the physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and p | dical Examiner | shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Probab Due to (or a: Avulsic Due to (or a: Cardion | Premosa consequence on of sa consequence on of | maturit uence of): osis uence of). Skin- uence of): | Righ | ıt Le | | | | | | Approximate Interval Between Conset and E | veen |
| P.O. Box 6 | The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as | Physician/Mec | JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Fetal | death 3 🗌 | Ectopic pi Other (sp | | | | | | ate of deliver | | 'ear |
| ords, P. | w requires that been signed b should be deta | ۾ | Part II. Dither significant conditions of Weight less than | | | | | | | | Be. Did tobacc | | tribute to the | | |
| al Reco | i ician: The law r certificete has be rector, page 2 sh | Completed | | | | | | | | - | a. Was an autopsy performed: | | death? | sy findings a pletion of ca 2 No | available tuse of |
| Division of Vital Records, | tending Physical Albath. tor: After this the funeral directions. | Certification; To Be | 25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b | 28a. Date of Inj (Month, Da | ury ay Year) | ER/Outpatient 28b. Time of Injury | M 2 | 8c. Injury Work′ 1 □ Y | 26. Place of I 4 Nursing at) es 2 No | g Home 5[28d. De | Residence escribe how in | jury occui | rred | | |
| Ω | epital or Al nours after neral Direc / filled in by | | 4 Homicide determined 29a. Certifier 1 Certifying Ph | building, e | of my know | vledge, death | occurred | at the time | e, date and pla | ace and due | y or Town, Sta | (s) and m | 20001 20 012 | lad | |
| • | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by | Medical | (Check only 2 Medical Examone) 29b. Signature and title of certifier | niner: On the basis of and manner st | or examinat | ion and/or inv | estigation | , in my opi c. License D571 | nion, death or number | courred at th | e time, date a | nd place, Date signe | and due to | the cause(s) lay, Year) | |
| • | | | 30. Name and address of person who | | | , , ,, | , | a:- | | | | | | - | |
| N. S. S. | Sta Registr | _ | Dawn Walton, M. Day, Year) NOV 1 0 20 | | orest rar's Signal | | Road | , 51] | ver Sp | ring, | MD 209 | 9TO | | | |

ORIGINAL

| | | 1 = For State Registrar Amend I | State of Maryland | | | | | Reg. No. UU5 | 38479 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------|--------------------------|--------------------------------------|---------------------------------|---------------------------------------------------------------------------------------|
| Physicia /Medic | _ | 1. Decedent's Name (First, Middle, Last) George M. Baker, | | | | | Novembe | er 27, 200 | 9ar 95 1046 |
| Examin | age of Fig. | 4a. Facility Name (If not institution, give s | | | 4b. City, Town, or | | th | 4c. County of I | |
| | M- 63 | Upper Chesapeake 5. Social Security Number 6. Sex | Medical Cente | | Bel A | | 8. Date of Bir | Harfor | d Birthplace (State or Fore |
| Funeral Director | | 213-32-2483 ¹ x | M 2□F 69 | Yrs. | Months Days | Hours Min | (Month, Da | y, Year) , 1936 | Country) Maryland |
| death with the Maryland ma 23a or 28a-1 show r mart be notified at | or | Usual Residence of Decedent | | , Town or Lo | cation | 1 | | | 10d. Inside City Lin 1 ☐ Yes 2 ☐ |
| 28a- | ect | 10e. Street and Number | u l | FC | 10f. Zip Code | <u> </u> | | 10g. Citizen of Wha | it Country? |
| 3a or | 0 | 112 Gwen Drive, U | nit L | | 2 | 1050 | | U.S.A | |
| be filed within 7.2 hours after death with the waryar tal Hygiene. tal Hygiene. d other than "netural", or itema 23a or 28a-1 show evant, the Modical Examiner must be notified at | by Funeral Director | | 2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 | Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No | | Specify Yes or No to Rican, etc.) | 14. Race - Black, \ Specify: | American Indian, White, etc. white |
| siled within 72 hours after I Hygiene. other than "netural", or ite ant, the Medical Examina | Completed b | 15. Decedent's Educ (Specify only highest grade | ation completed) | (Give | dent's Usual Occupa kind of work done of DO NOT use retired | during most of we | orking | 16b. Kind of Busin | ess/Industry |
| within ene. than | mc | Elementary/Secondary (0-12) | College (1-4or 5+) 4 | | intant | , | | defense | industry |
| Hygi Ther Int. | Ö | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | me (First, Middle | Maiden Sumame) | |
| | To B | George M. Baker, | Sr. | | | Margar | et Mary | O'Connor | |
| and Men | - | 19a. Informant's Name/Relationship (Ty) | pe, Print) | 19b. Mailir | ng Address (Street a | and Number or F | ural Route Numb | er, City or Town, Sta | ite, Zip Code) |
| deelth a the tre | | George M. Baker I | 20b. P | ace of Dispo | Cobin Rid | | , Baltin Date | ore, Md. 20c. Location - Cit | |
| nent of int: If it iry or o | | ty Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) | | | | | 12/1/20 | 05 Timoni | um, Md. |
| permit. Pages Department of I Important: If Its eny Injury or o | | 21. Signature of Funeral Service License Buein Ce Lee | | | | | | Bel Air, | |
| The law requires that the death certificate be executed It has been signed by the attending physician and oage 2 should be detached for use as the burial-transit | edical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or a))). | и еп се of): | Lune | g Ca | ncer | | Onset and Death 2 Wond |
| at the death certifics by the attending phatached for use as t | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de | death 3 | ⊒Ectopic pregnancy □ Other <i>(specify)</i> | | | 23d. Date o Month | |
| w requires that been signed b should be deta | þ | Part II. Other significant conditions con | tributing to death but not resu | ulting in the u | nderlying cause giv | en in Part I. | 23e. Did 1 | | ite to the cause of death |
| | e Completed | 25. Was case referred to medical | | | | 26 Place of D | 24a. Was auto perfo 1 Ves | psy prio dea 1 1 | re autopsy findings avail r to completion of cause th? Yes 2 \(\square\) No |
| ysicia is cert direct | 0 | examiner? | lospital: 1 Inpatient 2 | ER/Outpatier | nt 3 DOA Oth | 0.00 | | dence 6 Other | (Specify) |
| nng rn h. After th funeral | ation: T | 27. Manner of Death 1 | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | Wor | y at k? Yes 2 □ No | 28d. Describe | how injury occurred | |
| i i i i | Certification: | 3 Sutcide 6 Could not be determined | 28e. Pface of fnjury - At ho building, etc. (Specify | | reet, factory, office | | 28t. Location (City or To | | or Rural Route Number, |
| To the Hospital or within 24 hours afte To the Funeral Dil completely filled in | Medicai (| | sician: To the best of my kno ner: On the basis of examina and manner stated. | | | | | date and place, and | I due to the cause(s) |
| To the within comp | M | 29b. Signature and title of certifier | W | .D. | 29c. Licens | e number | | 29d. Date signed (A | Month, Dey, Year) x 28, 200 |
| | | (- 11011) | empleted cause of death (Item | 23a) (Type, | Print) Road | #200 | , Bel F | tir, me | 21014 |
| St Regist | ate trar | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ture | Goods | | | | |

| | | | 1 - For State Registrar | State of Ma | ryland / Depa <i>Ce</i> | artment of rtificate c | | and Mental H | ygiene Reg. N o. () () | 5 | 38480 |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------|----------------------------------|--------------------------|----------------------------------------------------|
| | Physici | an | Decedent's Name (First, Middle, Last) | | | | | 2. Date of D Month | eath Day | Year | 3. Time of Death |
| -10 | /Medic Examir | cal | Jessie Lee Bradl 4a. Facility Name (If not institution, give 1034 Wales Driv | street and number) | | 4b. City, Town | n, or Location o Lata | | /2005 4c. County Char | of Death | 18:00 м |
| | Funeral Director | | 410-03-2000 | | (In yrs. last birthday) | If Under 1 Ye Months Day | | 8. Date of B (Month, C | irth Pay, Year) 0/1904 | 9. Birthp Coun | lace (State or Foreign try) |
| | Maryland a-f show | tor | Usual Residence of Decedent 10a. State 10b. County MD | Charles | 10c. City, Town or Lo | LaPla | ata | | | 1 | 0d. Inside City Limits 1 Yes 2 No |
| | th with the 23a or 28 191 be not | al Director | 10e. Street and Number 1034 Wales Dri | ve | | 10f. Zip Code | 9 20646 | | 10g. Citizen of V | | try? |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show entry injury or other treumetic event, the Medical Examinar must be notified at once. | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ♣ Divorced | 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | 0 | Was Decedent of the Yes, specify C | | in? (Specify Yes or N Puerto Rican, etc.) | o- 14. Rac Blac Specify | e - Americ ck, White, | |
| 21215-0036 | within 72 ho iene. • then "netur fre Medical. | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | cation e completed) College (1-4or 5- | (Give | dent's Usual Occ kind of work do DO NOT use ret Domest | ne during most tired) | of working | 16b. Kind of Bu | | dustry Home |
| Maryland 2 | uld be filed Aental Hyg rked other tic event, l | To Be C | 17. Father's Name (First, Middle, Last) Wesley Thomas | | | | 1 | 's Name (First, Middl Celia | e, Maiden Suman Belcher | | |
| | and 2 should land No. 27 is mailtheame | | 19a. Informant's Name/Relationship (Ty Bonnie Larkin Wa | _{pe, Print)} tson/Daugl | nter 195. Mailin | ng Address (Stre Wales 1 | et and Number Drive, | r or Rural Route Num. Laplata Ma | ber, City or Town, ryland 2 | State, Zip 20646 | Code) |
| Baltimore, | Pages 1 ment of He ent: If iten ury or oth | | 20a. Method of Disposition 1 Burial 2 Cremation 3 (Specify) | | Elmwo | esition (Name of matory or other p od Cem | olace) | Date 11/30/2005 | 20c. Location - Birmi | | |
| Balt | permit. Departi Import eny inj | | 21. Signature of Funeral Service License | | \rightarrow 1 | 501 E. I | Fort Av | ens Funera enue, Balt | imore MD | Inc. | 30 |
| | Pnysician /Medical Examiner | | 23a. Part1. Enter the disease or compil shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | ne cause on each lin | the death. Do not enter. | | tying, such as o | cardiac or respiratory | arrest, | | Approximate Interval Between Onset and Death |
| 8760, | death certificate be executed e attending physician and for use as the burial-transit | Ical Examiner | Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | consequence of): | | | | - | | |
| .O. Box 6 | that the death certific ed by the attending p detached for use as t | hysician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 3c. If yes, outcome of 1□Live birth 24□Pregnant at 9□Unknown | 2 ☐ Fetal death 3 ☐ | Ectopic pregnal Other (specify) | | | 23d. Dat Mor | e of delive | ry Day Year |
| rds, P | w requires that the s been signed by th should be detache | by P | Part II. Other significant conditions con | stributing to death bu | t not resulting in the u | nderlying cause | given in Part I. | | tobacco use contr Yes 2 No | | e cause of death? ably 4 Unknown |
| Vital Records, | The law ate has b page 2 sl | Completed | | | | | | 24a. Wa: auto perf 1 \(\text{Yes} | opsy pormed? | prior to con leath? | osy findings available inpletion of cause of |
| /ita | Physicien: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | ospital: | | | | of Death (Check only | | | |
| of | di S | tlon: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injun (Month, Day | 28b. Time of | 28c. In W | other: 4 □ Num njury at vork? □ Yes 2 □ N | | idence 6 Other | |) |
| Division | tel or Attending I s after death. el Director: After ed in by the funer | Certification; | 3 Suicide 4 Homicide 6 Could not be determined | 28e. Place of Inju building, etc. | ry - At home, farm, str (Specify) | eet, factory, office | ж | 28f. Location City or To | (Street and Numbe wn, State) | er or Rurai | Route Number, |
| | To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral | edical | one) | sicien: To the best oner: On the basis of and manner state | f my knowledge, death examination and/or in- ed. | vestigation, in my | y opinion, death | place, and due to the n occurred at the time | , date and place, a | and due to | the cause(s) |
| . | 5 Miles | 2 | 29b. Signature and title of certifier 6 - Notice Signature | H.D | | DA | 0569 | 49 | 29d. Date signed | lni | - |
| | 21 | | 30. Name and address of person who co | mpleted cause of de | ath (Item 23a) (Type, Craw Sw gs Signature | Print) Y Suito | -102 | LaPlada 1 | ND Z04 | 246 | ` |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registra | s Signature | Joseph | , | | | | |

DHMH 17 Rev 1/2001

LEEN

| | | | 1 - For State Registrar | | /larylan | d / Depa | artmen | of H | lealth ar | | ental Hy | giene | 05 | 38 | 482 |
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| W. | Physici | an | Decedent's Name (First, Middle, | Last) | | | | | | | Date of De Month | | Year | 3. Ti | me of Death |
| | /Medi | | JAMES | | | BED | | | | | yoremp | cr 23 | | 5 2 | -0:30 M |
| 7. | Examir | ıer | 4a. Facility Name (If not institution, | | • | | | | | | | | | j | |
| 3 | | | | Compared to the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of the continuence of | | | | | | | | | | | |
| | Funeral Director | | 216-62-9623 Usual Residence of Decedent | | - | | | | | Min. | (Month, Da | y, Year) 0,1955 | Cou | ipiace (S intry) ary1a | State or Foreign and |
| | land | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | | 10d. Ins | ide City Limits |
| | h the Maryland r 28a-f show inotified at | Funeral Director | Maryland Ba | 1timore | | | 101.7 | 0.1 | Γ | Dunda | a1k | | | | Yes 2₺No |
| | with the sor | ā | 7841 Scholar | Road | | | 10f. Zip | Code | 212 | 222 | | _ | | | |
| | eath | era | 11. Marital Status | | nt Ever in U | S 13 V | Was Deced | ant of Hi | isnanic Origin | n2 (Spac | ify Yes or No | | | | 30 |
| 36 | hours after death with the Maryland tural', or Items 23a or 28a-f show at Examiner must be notified at | by Fun | 1 Never Married *** Marrie 3 Widowed 4 Divorced | Armed Forces d 1 ☐ Yes 223 If Yes, Give | s?] No | | | | | Puerto R | ican, etc.) | | ack, White, | , etc. | |
| Maryland 21215-0036 | 72 hours "natural", dical Ex | ed | 15. Decedent's | | | 16a. Deced | lent's Usua | Occupa | ation | | | 16b Kind of | Rusiness/Ir | Whit | |
| 215 | nin 72 n "nat | Completed | (Specify only highest Elementary/Secondary (0-12) | grade completed) | - 5 -) | (Give | kind of wor. | k done d | durina most o | f working | 7 | TOD. KING OF | Du3111633/11 | luusiiy | |
| 212 | d within giene. rr than " | E | Elementary/Secondary (0-12) | | r 5+) | | Buver | | | | | Contir | nenta: | 1 Ca | n Co. |
| þ | should be filed within ind Mental Hygiene s marked other than " umatic event, ins Mai | Bec | 17. Father's Name (First, Middle, L. | ast) | | | Dayor | | 18. Mother's | Name (| First, Middle, | | | | |
| <u>a</u> | uld be denta denta rked rked | To B | Charles A. Be | ednar | | | | | | Н | ilda L | ouise I | owell | L | |
| ary | should be made with the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same o | | 19a. Informant's Name/Relationshi | | | 19b. Mailin | g Address | (Street a | and Number o | or Rural. | Route Numbe | or, City or Tow | n, State, Zij | p Code) | |
| Σ | alth alth a | | Mrs. Linda J. | Bednar (Wi | ife) | 784 | 1 Sch | olar | Road | $\mathtt{D}\mathbf{u}$ | ndalk, | Maryla | and 2 | 2122 | 2 |
| J. | of He | | 20a. Method of Disposition | | | lace of Dispo | sition (Nam | e of | e) | Da | te | 20c. Location | - City or T | own, Sta | ate |
| Ĕ | Page sent c nt: If ry or | | 1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | Θ | | | | 1 | 11/2 | 8/2005 | Midd] | le Riv | ver. | MD |
| Baltimore, | permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other traumatic. 000ce. | | 21. Signature of Funeral Service Li | censee | 110 | 22 | Name and | Addres | s of Facility | | | | | | |
| Õ | Depa Impo any ir | | LOCACE. | | | | | | | | | | | | |
| | Physician /Medical Examiner | Examiner | shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a | line. مین کی هر پر is a consequ | c.e h mo uence of): | | | | 23/6 | espiratory an | 1651, | | Interva Onset | ximate al Between and Death |
| . Box 68760, | death certificate be executed ettending physicien end ind for use as the burial-transit | Physician/Medical Exa | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | d | e of pregna 2 ☐ Fetal at time of de | ncy death 3 | | | | | | | | ery Day | Year |
| P.0 | t the by th | hys | 9 Unknown | 9Ll Unknown | | | | | | | | | | | |
| | requires that the de een signed by the e nould be detached f | þ | | | | ulting in the ur | ndertying ca | use give | in in Part I. | | | | | | |
| Ö | > 00 | lete | | | , | | | | | | 24a Was | an 24h | Wore auto | ney fine | inos avadable |
| I Re | The ete ha | Completed | | | | | | | | | autop | sy med? | prior to co death? | mpletion | n of cause of |
| /ita | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | | | | | | | | Check only o | 7e) | | | |
| _ | D is | ို | 1 ☐ Yes 2 No | 1 paunpa | | ER/Outpatien | | Othe | r: 4 ☐ Nursii | ng Home | 5 🗆 Resid | ence 6 🗆 Ot | her (Specif | (y) | |
| ion | nding Path. r: After t e funera | atlon: | 27. Manner of Death 1. Natural 5 Pending 2 Accident investiga | | jury Pay Year) | | | c. Injury Work | at ? | 28 | | | | | |
| Division of Vital Records, | To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 3 Suicide 6 Could no 4 Homicide determin | ad 288. Place of I | njury - At ho etc. (Specify | me, farm, stre | eet, factory, | office | | 28 | f. Location (S City or Tow | itreet and Num n, State) | ber or Rura | I Route | Number, |
| | e Hospit 24 hour Funera letely fills | edicai (| 29a. Certifier (Check only one) 1 **Certifying 2 ** Medical Expression 1. ** | caminer: On the basis | of examinat | wledge, death ion and/or inv | occurred a estigation, | t the tim | e, date and p inion, death o | olace, an | d due to the o | ause(s) and materials | anner as s and due to | tated, the car | ıse(s) |
| | To th within Fo th | Me | 29b. Signature and title of certifier | | | | 29c. | License | number | | | 29d. Date sign | ed (Month, | Day, Ye | ar) |
| | | | > 1 10 m. | fil ma | V | 6 + A. | امن | | REC = | 00 | | í\ | 1211 | 20 | |
| 10 | 7 | | 30. Name and address of person w | no completed cause of | death (Item | 23a) (Type, I | Print) | She | it, Bal | 14,1 | She 141 | 0 212 | 12310 | /3 | |
| | Sta Benistr | te | 31. Date filed (Month, Day, Year) | | | | | | | | | | | | |
| | Registr | | NOV 3 0 20 | 111 | s St. | SURA | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiepe Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 24, 2005 **Physician** Geraldine Fogle Basore 10:50am M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kline Hospice House Mount Airy Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 ☐ M 2ঁ ÅF 89 1916 West Virginia Director 213-16-0474 Jan. Usual Residence of Decedent filed withIn 72 hours atter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow or than "natural", or Itema 23a or 28a-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 12905 Little Antietam Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Completed by 3 ☐ Widowed 4 Ĭ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse n and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If tem 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဥ Charles Eugene Kern Edna Mae Keyser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12905 Little Antietam Road, Hagerstown, MD 21742 Michael Basore, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Fairview Lutheran Cem. 11/28/2005 Harpers Ferry, W. V. 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signature of Juneral Service Licensee _M00999 23a. Part1. Enjet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or spart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 STIVE **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Year Month 4□Pregnant at time of death 5 Other (specify) page 2 should be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2.00 1 Yes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No Physician: tuneral director Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 EN/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Atter or Attending 5 Pending investigation after death. 1 🗌 Yes 2 No 2 Accident the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours at To the Funeral D completely tilled i Hospital Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 009689 25 0 25 26112 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 300 West Ninth Street, Frederick, Maryland Jr., MD, Austin Pearre, 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 3 ^ 2005

| | | 1 - For State Registrar | State of M | Marylar | | artmer <i>rtificat</i> | | | nd Me | | jiene | 005 | 38484 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------|-----------------------------------|---------------------------|-----------------------|-----------------------------|-----------------------|------------------------------------|-------------------------|---------------------------------------------------|-----------------------------------------------|
| Physic | nian | 1. Decedent's Name (First, Middle, L. | ast) | | | | | | 2 | 2. Date of Dea Month | th Day | Year | 3. Time of Death |
| /Med | | Virgil De | | | | | | | | Nov. | | 2005 | 1:09p. ^M |
| Exami | iner | 4a. Facility Name (If not institution, gr | | | | 4b. City, | Town, or | Location of | Death | | | ounty of Death | |
| | | Southern Mary 5. Social Security Number 6. | | | last birthday) | If Under | Clin | ton If Under 2 | 4 Hrs | 3. Date of Birth | | orges | |
| Funera Director | | | 1 X M 2□ F | 8.5 8.5 | | Months | | Hours | Min. | Month, Day | , Year) | 9. Birti | nplace (State or Foreign untry) |
| | | Usual Residence of Decedent | | | | 1 | | | | lay ZZ, | 1920 |) WIII | iamsport, |
| urylan show | _ | 10a. State 10b. County | | 10c. Ci | ty, Town or Lo | ocation | | | | | | | 10d. Inside City Limits |
| Ba-f | Director | | Georges | | Clinton | | | | | | | | 1 X Yes 2 □ No |
| with the | | 10e. Street and Number | _ | | | 10f. Zip | | | | 1 | 0g. Citize | n of What Cou | untry? |
| eath y | erai | 11402 Accolade | 12. Was Deceden | t Ever in I | 10 12 | | 735 | | :-0./0 | * | | SA | |
| ter d | Funeral | 11. Marital Status 1 □ Never Married 2 □ Marned | Amed Forces | \$? | 7.5. | If Yes, spe | cify Cuba | n, Mexican, | Puerto Ri | ify Yes or No- ican, etc.) | 14. | Race - Amer Black, White | |
| Maryland 21213-0035 d 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene. 77 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Modical Examinational be notified at | b | 3 XWidowed 4 ☐ Divorced | If Yes, Give Year or Dates | LILI | II | 1 🗆 Yes | 2 X) No | Specify: | | | S | pecify: | Black |
| 72 ho | Completed | 15. Decedent's E | | | 16a. Dece | dent's Usu | al Occupa | ition | | | 16b. Kind | of Business/I | |
| within 7 | pie | (Specify only highest g | College (1-4o | r 5+) | life. | DO NOT u | se retired, | luring most | ot working | 7 | | | |
| nd 2121 e filed within at Hygiene. other then | S | 10 | | | Load | Maste | r Su | pervi | sor | | Ai | clines | |
| De fill Hai Hai Hai Hai Hai Hai Hai Hai Hai Hai | Be | 17. Father's Name (First, Middle, Las | st) | | | | | 18. Mother | 's Name (| First, Middle, i | Maiden Su | imame) | |
| ylan louid be i Mentai marked o | ဥ | Isaiah Bruce | | _ | | | | | | ances H | | | |
| Ore, Marylal as 1 and 2 should to of Health and Ment litem 27 is marked rother traumatic e | 1 | 19a. Informant's Name/Relationship | | | | | | | | Route Number | | | , |
| D BELL | | Lester C. Hollin 20a. Method of Disposition | igsworth/s | | 114 Place of Dispo | 02 Ac | cola | de Co | urt Da | Clinto | | 2073 tion - City or T | |
| Saltimore, bermit. Pages 1 ar Depertment of Hea mportent: if item injury or othe | | 1 Burial 2 Cremation 3 | | θ ' | cemetery, crei | matory or c | ther place | ´ | No | v. 26 | | | |
| Baltimore permit. Pages 1 Depertment of the importent: if its any injury or ot once. | | 4 Donation 5 Other (Spec | | The | Cumbe | | | mator s of Facility | | 006 | | berland | i, MD |
| Derm Deperm Impo | | Back | BALLE | 11 | - | | | | Omi | th Fun Keyser | | | |
| | | 23a. Part1. Enter the disease, or cor | molications that cause | ed the deat | | | | | | | | 2672 | Approximate |
| be executed sicien and burial-transit | i Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Oue to (or a | | | | | | | | | | |
| The COLIDS, P.O. DOX 00/00, The law requires thet the death certificate be executed the has been signed by the attending physicien and bage 2 should be deteched for use as the buriat-transit. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | d | 2 Feta | aldeath 3□ | Ectopic pi Other (sp | | | | 38 - | 230 | I. Date of delik | very Day Year |
| tures the n signed I | | Part II. Other significant conditions ATRIAL FI | contributing to death | | sulting in the u | nderlying o | ause give | n in Part I. | | | oacco use | | the cause of death? |
| | Completed by | | | | | | | | | 24a. Was a autops perform | y ned? | 24b. Were aut prior to co death? 1 ☐ Yes | opsy findings available ompletion of cause of |
| ysicien: Th ysicien: Th is certificate director, pag | Be | 25. Was case referred to medical examiner? | Hospital | | | | 16. | | of Death (| Check only on | e <i>)</i> | | |
| Or VITA Physicien: this certific ral director, | 10 | 1 ☐ Yes 2 ∰ No 27. Manner of Death | Hospital: 1 Inpa | | ER/Outpatier | | | 4 🗆 Nurs | | 5 Reside | | | fy) |
| ding ding After | 0 | 1 Natural 5 ☐ Pending | 28a. Date of In (Month, D | ay Year) | 28b. Time of Injury | M | 8c. Injury Work | | | d. Describe ho | w injury o | ccurred | |
| DIVISION To the Hospital or Attending within 24 hours after death To the Funeral Director: Attention completely filled in by the fune | Certification: | 2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine | be 28e. Place of I | njury - At h etc. <i>(Speci</i> | ome, farm, str fy) | | | ′es 2⊡N | | f. Location (St City or Town | reet and N n, State) | lumber or Rur | al Route Number, |
| Le Hospital ne Hospital ne Funeral ne Funeral | edicai C | 29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa | Physician: To the besiminer: On the basis and manner: | of examina | owledge, death ation and/or in | occurred vestigation | at the time, in my op | e, date and inion, death | place, an occurred | d due to the ca at the time, da | tuse(s) an | d manner as s | stated. to the cause(s) |
| To the within 2 To the complet | Me | 29b. Signature and title of certifier | | | | 290 | . License | number | | 2 | 9d. Date s | igned (Month, | Day, Year) |
| 6/ | | Victor E | · Herry | 2.M. | • | 2 |)20 | 986 | | | 11-1 | 7-20 | 20 |
| 111)- 2 | | 30. Name and address of person who | | 7 | | | | | | | . • | | |
| | 1 | | | | | | | | | | | | |
| <u></u> | | 9/31 PISCA | TAWAY R | d (| CLINE | | MD | 2 | 073 | tV Z | ctor | E. Her | rry, M.D. |

| | | 1 - For State Registrar | State of Maryla | nd / Depa <i>Ce</i> | artment of Hi rtificate of L | ealth and N Death | | ene 005 | 38485 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------|------------------------------------------|-------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| Physic /Med | | Decedent's Name (First, Middle, Last) | Hattie 1 | Mae B | ennett | | 2. Date of Death Month 11 | Day Year 23 2005 | 3. Time of Death 5:55 p. M |
| Exam | | 4a. Facility Name (If not institution, give s | treet and number) | | 4b. City, Town, or | Location of Death | | 4c. County of Dear | |
| | | | use | | Balto | | | N/A | |
| Funera Director | | 214-26-3835 | 7. Age (In yr. | s. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 7-6-19 | Year) Co | thplace (State or Foreign buntry) N.C. |
| and w | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| Aaryli sho | 5 | Md N/ | | Balto | | | | | 1 X Yes 2 No |
| the N | Director | 10e. Street and Number | - | | 10f. Zip Code | | 10 | g. Citizen of What Co | •• |
| with | | 511 Allendale Sti | | | | 229 | | | |
| deeth | Funeral | | 2. Was Decedent Ever in | U.S. 13. | Was Decedent of His If Yes, specify Cubar | | pecify Yes or No- | USA | erican Indian, |
| nore, Maryland 21215-0036 siges 1 and 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. If I tem 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Erain, ser must be notified at | þ | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: | | lf Yes, specify Cubar 1 ☐ Yes 2 🛣 No | Specify: | o Rican, etc.) | Black, Whit | e, etc. lack |
| 5-0 72 ho | Completed | 15. Decedent's Educ (Specify only highest grade | | 16a. Dece | dent's Usual Occupa kind of work done d | ition | 1 | 6b. Kind of Business | Industry |
| 21. Fair 1. | ple | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired) | uning most of won | ang | | |
| 21 ad wi | Con | 10th grade | N/A | | Custodia | | | Departmen | t Store |
| tal H | Be | 17. Father's Name (First, Middle, Last) | | | | | ne (First, Middle, M | | |
| Via Mould Men Men Men Men Men Men Men Men Men Men | 2 | Richard Goodson | | | 1 | | e Mae Ree | | |
| Maryland Id 2 should be file tith and Mental Hy R7 is marked oth traumatic event | | 19a. Informant's Name/Relationship (Type Carrie Moore - Dau | · · | | ng Address (Street a Craigmon | | | City or Town, State, 2 | Zip Code) |
| Heal Heal tem 2 | | 20a. Method of Disposition | | Place of Dispo | sition (Name of | 1 | 400 00 00 | Oc. Location - City or | Town, State |
| Pages ent of nt: If I | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify) | | | natory or other place ark Cemete | | 28-2005 | Balto, Md | |
| Baltimore, Mispering Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra | | 21. Signature of Juneral Service License | | | . Name and Address | s of Facility Ma | arch F/H | | |
| 4-25 15-54 | | 23. Part1. Exter the disease, or complic | ations that caused the de | ath. Do not ent | | | | | Approximate |
| Commence of the | | shock, or heart failure. List only on Immediate Cause (Final | e cause on each line. | 3 | | | , , , , , , , , , , , , , , , , , , , , | | Interval Between Onset and Death |
| Physician /Medical | | disease or condition resulting in death) | Due to (or as a conse | olon Ca | ncer | | | | 1 year |
| Examiner | | | 200 (0) 23 2 001130 | squorios or). | | | | | 4 |
| 7 7 7 | ner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying | Due to for as a cons | oneuce of j. | | | | | |
| ocuted ind | Examiner | Cause (Disease or injury that initiated events | | | | | | | |
| 68760, cate be executed physician and the burial-transit | | resulting in death) Last | Due to (or as a conse | equence of): | | | | | |
| 87 cate t | dlcal | d | | | | | | | |
| P.O. BOX 6 that the death certific ed by the attending I detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | Bc. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown | tal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of del Month | ivery Day Year |
| I Records, P.O. The law requires that the site has been signed by the page 2 should be detached. | Ď | Part II. Other significant conditions con | tributing to death but not re | sulting in the u | nderlying cause give | n in Part I. | | acco use contribute to | |
| Cord | ete | | | | | | 24a. Was an | | |
| | Completed | | | | | | autopsy perform | ed? prior to death? | topsy findings available completion of cause of |
| f Vita ysician: us certific director, | Be | 25. Was case referred to medical examiner? | ospital: | | Othe | e: | th (Check only one | , | -1 |
| Of Phys | 5 | 1 Yes 2 No | 1 ☐ Inpatient 2 [28a. Date of Injury | ER/Outpatier 28b. Time of | 3L DON | 4 Nursing no | ome 5 Resider | | City) Hospice |
| ding h. After funer | tlon | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | Work | es 2 □No | 200. 00001100 1104 | rigary occurred | |
| Division of Vita to Attending Physician: after death. Director: After this certification by the funeral director, | flca | 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of Injury - At | home, farm, str | | | 28f. Location (Stre | et and Number or Ru | ral Route Number. |
| Diversities and in the | Certification: | 4 Homicide | building, etc. (Spec | city) | | | City or Town, | State) | |
| Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | edical (| 29a. Certifier 1 Certifying Phys (Check only one) | ician: To the best of my kr er. On the basis of examinand manner stated. | nowledge, death nation and/or in | n occurred at the time vestigation, in my op | e, date and place, inion, death occur | and due to the car red at the time, da | use(s) and manner as te and place, and due | stated. to the cause(s) |
| To th withir To th comp | Me | 29b. Signature and title of certifier | 1 | | 29c. License | | | d. Date signed (Monti | n, Day, Year) |
| | | Jun Koll | MD | | | 51788 (| | 11-23- | 2005 |
| 3 | | 30. Name and address of person who con | repleted cause of death (Ite Polk MD 6: | em 23a) (Type, 20 Bait | Print) on Street | Bel Air | MD 21014 | | |
| Si Regis | ate trar | 31. Date filed (Month, Day, Year) NOV 3 0 20 | 32. Registrar's Sign | nature | Print) on Street | | | | |

| | | | riease | ype or Prin | III Black II | idelible liik. | Elisure Ali | Copies Ar | e Legible. | |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------|--------------------------------------------|----------------------------------------------|----------------------------------------|--------------------------------------------------|
| | | | For | State of Ma | ryland / Dep | artment of He | alth and M | ental Hygie | 2005 | 38486 |
| | | | State Registrar | | Ce | ertificate of De | eath | Reg. | | |
| | Physici | an | 1. Decedent's Name (First, Middle, Las | | OWEN | | | | Day Year | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | | O MO. I | 4b. City, Town, or Lo | | NOVEMBER | 22 200 4c. County of Dea | |
| | | | HARBOR HOS | | NTER | BALTIN | | | | |
| | Funeral Director | | 220-20-3719 | ox 7. Age □ M 2/√ F | (In yrs. last birthday Yrs. | | f Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Ye 11 14 | 9. Bir 28 | thplace (State or Foreign ountry) MD |
| pac | A = | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits |
| Mon | B-f sh | tor | MD NA | | Baltim | ore | | | | 1 X Yes 2 ☐ No |
| dib. | or 28 De no | Funeral Director | 10e. Street and Number | | | 10f. Zip Code | 25 | 10g. | Citizen of What C | |
| theo | 18 238 | erai | 16 Henson Ave | 12. Was Decedent E | verin IIS 13 | 212 | | ocify Ves or No- | 14. Race - Am | |
| 1 Z 1 3-0030 | perfilt. Tages I safe about the water is a room as a recovery and perfilt registration of the safe and Mantal Hygione. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. It a Modical Examiner must be notified at QDCs. | by Fun | 1 Never Married Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes XNO If Yes, Give Year or Dates: |) | . Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No | Mexican, Puerto I | Rican, etc.) | Black, Whi | |
| 20-c | atura ical E | ted | 15. Decedent's Ed | lucation | 16a. Dec | edent's Usual Occupation | on | 168 | . Kind of Business | |
| 7 Z | han r | Completed | (Specify only highest gra | College (1-4or 5+ | -) | e kind of work done dur DO NOT use retired) | ring most or workii | ng | 17 | |
| 7 0 | Hygiel ther t | e Co | 12th grade 17. Father's Name (First, Middle, Last) | na | Н | ousewife | 8 Mother's Name | (First, Middle, Mai | Home | : |
| | ked o | To Be | William Milbur | | | | iolet J | | our carrame, | |
| ary | n and Mental Hygiene. 7 is marked other than "r. raumatic event, It e Med | - | 19a. Informant's Name/Relationship | | | ling Address (Street and | d Number or Rura | l Route Number, C | | |
| ∑, 3 | ealth m 27 i | | Meldenardo Bow | en-Husbar | | Henson Av | | | | 215.5 |
| | If ite | | 20a. Method of Disposition X Burial 2 □ Cremation 3 □ 4 □ Deposition 5 □ Other (Specify | Removal from State | 1 | position (Name of ematory or other place) | | 1 | . Location - City or | 10.00 |
| Baltimor | artmer ortant injury | | * 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Liter | | | Memorial 22. Name and Address | | 3/05 Ar | butus, | Ма |
| מ | Depa Impo | | 1 Plus | Kek | M 4 | arch F/H 300 Wabas | west h Ave, | Baltimo | re, Md | 21215 |
| | | asc. | 23a. Part . Enter the or ease, or com sho >, or heart failure. List only | plications that crused to | he death. Do not e | nter the mode of dying, | such as cardiac o | r respiratory arrest, | | Approximate Interval Between |
| | hysician | | Immediate Cause (Final disease or condition resulting in death) | a. NON Sh | TALL CEL | L LUNG C | ARCIN | OMA | | ONE YEAR |
| | /Medical Examiner | | resulting in death) | Due to (or as a | consequence of): | | | | | |
| F | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that parties are sentential) | b. Due to (or as a | consequence of): | | | | | |
| V | oe executed ician and burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | |
| / oC, | ician a | cai Ex | resulting in death) cast | Due to (or as a | consequence of): | | | | | |
| | phys s the | | | . d | | - | | | | |
| POX | anding use a | In/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of | | □Ectopic pregnancy | | | 23d. Date of de | livery |
| ם כ | requires traitine dearth cerminate be executed een signed by the attending physician and nould be detached for use as the burial-transit | Physician/Medi | in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown | 4□Pregnant at t | | Other (specify) | | | Month | Day Year |
| 7 | ed by detac | | Part II. Other significant conditions of | ontributing to death bu | t not resulting in the | underlying cause given | in Part I. | 23e. Did tobac | co use contribute t | o the cause of death? |
| cords | s been signed to should be deta | ed by | END STAGE | | | | | 1 ☐ Yes | 2 □ No 3 P | robably 4 ⊡Unknown |
| 0 | | ompieted | | | | | | 24a. Was an autopsy | 24b. Were a | utopsy findings available completion of cause of |
| I A | ate h page | Com | | | | | | performed | death? | s 2 No |
| VITAL | this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: | | Othor | | (Check only one) | | |
| 0 | this d | To: | 1 Yes 2 No 27. Manner of Death | 1 Snpatier 28a. Date of Injun (Month, Day | | | 4 Nursing Flor | me 5 Residence 28d. Describe how i | | ecify) |
| 0 | death. tor: After the the funera | ation | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | | Year) Injury | | s 2 🗆 No | | | |
| DIVISION | \$ 50 Kg | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Inju building, etc. | ry - At home, farm, s (Specify) | street, factory, office | : | 28f. Location (Stree City or Town, S | t and Number or R tate) | ural Route Number, |
| 1 | A hours Funera ely fille | Medical C | 29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar | ysician: To the best on niner: On the basis of and manner stat | examination and/or i | ath occurred at the time, investigation, in my opin | , date and place, a nion, death occurre | and due to the caus ed at the time, date | e(s) and manner a and place, and du | s stated. e to the cause(s) |
| ļ | within 2 To the | Me | 29b. Signature and title of certifier | 4 0 4 | | 29c. License n | | | Date signed (Mon | |
| | | | RAJasti Pal | epu MD | | RES | 000 | Nov | EMBER, | 22 , 2005 |
| | 3 | | 30. Name and address of person who RAJASRI PALES | | ath (Item 23a) (Type S HANOV | | BALTIMO | RE MO | 21225 | |
| * | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) | 32. Registra | r's Signature | de | | | - | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥎 3. Jime of Clean 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav Year THELMA VIRGINIA BERENDS NOV. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 216-12-9656 86 Yrs. Director 7/17/1919 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County r then "natural", or itame 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits Director MD CARROLL WESTMINSTER 1X Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 95 TIMBER RIDGE DR. 21157 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: WHITE Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 9 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fit.
Depertment of Health, and Mental Hy
Important: if Item 27 is marked oth
eny fluly or other traumatic event Be 18. Mother's Name (First, Middle, Maiden Surname) BERNARD SMITH NELLIE LLEWELLYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. McDOWELL-DAUGHTER 95 TIMBER RIDGE DR., WESTMINSTER, MD 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Commeterly, crematory or outer prace)

1 Description 5 Other (Specify)

ALL COUNTY CREMATION 11/28/05 SYKESVILLE, MD. (4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Ignatura Tuneral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 Parly. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) I ENTRICUL AR **Physician** STANDSTILL custary /Medical Due to (or as a consequence of): Examiner YPOTE NISTON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cardio Voscular disa. The law requires thet he death certificate be executed physicien and s the burial-transit Be Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e d be detached f o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ₺ No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 VP Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s effer derrel Director: Alt 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 6 filled in To the Hospital of within 24 hours of To the Funeral E completely filled it 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Chritigaliedu Nagannes D18200 11/28/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRACHED C Rd. west minuster 700-A pade Month, Day, Year)
NOV 3 0 2005
Sieve St Specific 31. Date filed (Month, Day, Year) State Registrar

| Γ | • • | partment of Health and Mental Hydis | |
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| | State of Maryland / Dep 1- State Amend Item 4b&Unpend Item 23a&2/e | per me C850 12-13-05 tas Prificate of Death | . N2 0 0 5 3 8 4 8 8 |
| Physician | Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day Year 3. Time of Death |
| /Medical | James Lester Bailey II | November 4b. City, Town, or Location of Death | 26 2005 10:25 A ^M 4c. County of Death |
| Examiner | 4a. Facility Name (If not institution, give street and number) 2 Kimball Ridge Court | -Woodlawn Catonsville | Baltimore |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday | (v) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days) Hours Min. Jan. 23, | |
| Director | 218-70-0833 1LXM 2LIF 47 Yrs. | Jan. 23, | 1958 Maryland |
| Maryland -f show lied at | 10a. State 10b. County 10c. City, Town or L | ocation | 10d. Inside City Limits |
| i or 28s-f st be notified Director | MD Baltimore | Catonsville | 1 Tyes 2 No |
| 1215-0036 within 72 hours after death with the ene. then "naturel; or iteme 23e or 28e he Medical Exercities must be not | 10e. Street and Number 2 Kimball Ridge Court | | g. Citizen of What Country? United States |
| fler death v r iteme 23e frer must | | . Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| urs after L', or its | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates: | 1 ☐ Yes 2 ☑ No Specity: | Specify: White |
| 21215-0036 ad within 72 hours att gliene. or than "natural", or or than "wadical Exertal t. the Madical Exertal | 15 Decedent's Education 16a, Dec | edent's Usual Occupation 10 | 6b. Kind of Business/Industry |
| 215 thin 73 the normal | Flementary/Secondary (0-12) College (1-4or 5+) | e kind of work done during most of working DO NOT use retired) | Chast Matal |
| nd 21215-00 be filed within 72 hou tal Hygiene. d other than "nature avent, the Medical event, the Medical Be Completed | 17. Father's Name (First, Middle, Last) | Mechanic 18. Mother's Name (First, Middle, Me | Sheet Metal |
| ylanc build be f Mental H arked of attic ava | Towns T. Dadless Co. | Patricia Lupo | , |
| Baltimore, Maryland 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Heelth and Mental Hygiene. Important: If tiem 27 ie marked other than "natural", or itama 23a or 28a-f shou any I sjury or other traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print) 19b. Mail | ling Address (Street and Number or Rural Route Number, | |
| e, M t and it sm 27 ther tr | James L. Bailey III Son 2 Ki 20a. Method of Disposition 20b. Place of Disp | imball Ridge Ct., Catonsvil | 1e, MD 21228 Oc. Location - City or Town, State |
| nord ages and of h | 1 M Burial 2 Compation 3 D Bemoval from State | ematory or other place) | altimore, MD |
| Baltimore, pend, pages 1 at Depertment of Hee mportant: If tem my isjury or othe page. | 121111111111111111111111111111111111111 | 22. Name and Address of Facility Ambrose Fun | |
| 0 88 8 8 | Repen Rom 1 | 1328 Sulphur Spring Rd., Ar | btus, MD 21227 |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final | nter the mode of dying, such as cardiac or respiratory arres | st, Approximate Interval Between Onset and Death |
| Physician /Medical | disease or condition resulting in death) a. Cardiomegaly Due to (or as a consequence of): | | |
| Examiner | | | |
| executed in and ial-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | |
| 760, te be executed ysicien and te burial-transit | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | |
| a price pa | d | | |
| sion of Vital Records, P.O. Box 687 and the death certificate anding Physician: The lew requires that the death certificate sath after this certificate has been signed by the ettending physic functor, page 2 should be detached for use as the sation; To Be Completed by Physician/Medic | IF FEMALE: 23c. If yes, outcome of pregnancy | | 201 Day 44 Day |
| Box leath cert ettendin for use | 23b. Was decedent pregnant in the past 12 months? 1 \(\times \) 2 \(\times \) No \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) 1 \(\times \) | ☐Ectopic pregnancy ☐ Other (specify) | 23d. Date of delivery Month Day Year |
| P.O. | 9 ☐ Unknown | | 1 |
| cords, Powrequires that is been signed to should be detailed by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Poieted by Po | Part II. Other significant conditions contributing to death but not resulting in the | | acco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown |
| Division of Vital Records, to Attending Physician: The law requires that death. Director: Atten this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by | | 24a. Was an | |
| The lev rate has page 2 | | autopsy | pnor to completion of cause of ed? death? □ No □ Yes 2□ No |
| f Vital F ysticien: Th is certificete director. pag | 25. Was case referred to medical examiner? | 26. Place of Death Check only one | |
| Of V Physic this co | 1⊠Yes 2□No Hospital: 1□Inpatient 2□ER/Outpatie | | nce MMOther (Specify) Scene |
| ion o' nding Ph ith. : After th s funerel | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury | | ,., |
| Bivision c tal or Attending P is after death. al Director: After t ed in by the funere Certification: | 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify) | street, factory, office 28f. Location (Street, factory, office City or Town, | eet and Number or Rural Route Number, State) |
| oital or urs after or illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in Illed in | | | ver(a) and manner as stated |
| Division To the Hospital or Attention within 24 hours after dealt To the Funeral Director: completely filled in by the Medical Certifical | 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated. | arn occurred at the time, date and place, and due to the cal investigation, in my opinion, death occurred at the time, date | te and place, and due to the cause(s) |
| To the within To the comple | 29b. Signature and title of certifier | 29c. License number 29 | d. Date signed (Month, Day, Year) |
| | Monjone The Youll it | | ovember 27, 2005 |
| w | 30. Name and address of person who completed cause of death (Item 23a) (Type | e,Print) 111 Penn Street Baltimon | ce, Maryland 21201 |
| State | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | , , , , |
| Registrar | NOV 3 0 2005 | Sparti | |

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| | | | 1 - For State Registrar | State of M | aryland / Dep <i>Ce</i> | artment of F | | - | ene | E., | 30100 |
|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------|-----------------------------------|-------------------------|-----------------------------------------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, Las | • | | | | 2. Date of Death Month | Day y | ear | 3. Time of Death |
| ~ | /Medi Examir | cal | 4a. Facility Name (If not institution, give | | Bellofatto | 4b City Town o | r Location of Death | November | 4c. County of | | 10:05 P ^M |
| | Exami | iei | 1019 5th Street | | | Laurel | Location of Death | 1 | Prince | | orge 's |
| | Funeral Director | | 210 32 1123 | 9x 7.Ag □ M 2 1□ F | ge (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | (Month, Day, Y | (ear) | . Birthpl | lace (State or Foreign try) Land |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10 | Od. Inside City Limits |
| | a Mary | ctor | MD Prince G | eorge's | Laurel | | | | | | 1X Yes 2 □ No |
| | or 28 | Olre | 10e. Street and Number | | | 10f. Zîp Code | | 10g | . Citizen of Wh | at Count | try? |
| | s 23a | ral | 1019 Fifth Stree | | | 207 | | | USA | | |
| 336 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Modical Examination in this and page. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: | No | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🌠 No | ispanic Origin? (Spanic Origin) (Spanic Origin) (Specify: | pecify Yes or No- p Rican, etc.) | 14. Race - Black, Specify: | White, e | an Indian, etc. ite |
| 5 | 72 hou natura | eted | 15. Decedent's Ed (Specify only highest gra | ucation | 16a. Dece | dent's Usual Occup | ation | 16 | b. Kind of Busir | ness/Indi | ustry |
| Baltimore, Maryland 21215-0036 | within ane. than | Completed | Elementary/Secondary (0-12) | College (1-4or | 0+) | kind of work done of DO NOT use retired | during most of won | king | | | _ |
| d 2 | filed Hygie other ent, II | | 17. Father's Name (First, Middle, Last) | <u>w</u> | | Cashier | 18. Mother's Nam | e (First, Middle, Ma | Giant | Food | ā |
| /lan | uld ba Jental rkad tic ev | To Be | Noah Sealock | | | | | rah F. Wi | • | | |
| lar | 2 sho and h is ma | | 19a. Informant's Name/Relationship (7 | | 19b. Mailir | ng Address (Street a | | ral Route Number, C | | te, Zîp (| Code) |
| ≥ | 1 and Health Im 27 | | Joseph Bellofatto 20a. Method of Disposition | /Husband | 1019 | Fifth St | treet, La | | 20707 | | |
| nor | ages int of H t: If ite | | 1 Surial 2 ☐ Cremation 3 ☐ | Removal from State | 20b. Place of Dispo | | | | c. Location - Cit | | |
| 붍 | mit. Poartme | | 4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service License | | Crestlawn | | | naldson F | arriott | | |
| m | Dep Imp | 1 - | Januar 3/ | 2001CM | | | | , Laurel, | | 0707 | |
| | Physician | | 23a. Part1. Prier the disease, or come shock or heart failure. List only of Immediate Couse (Final disease or condition | | ithe death. Do not entone. castatic Br | | | or respiratory arrest, | | ! | Approximate Interval Between Onset and Death Months |
| | /Medical Examiner | | resulting in death) | Due to (or as | a consequence of): | | | | | | |
| K | uted | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Underlying that initiated events | b. Due to (or as | a consequence of): | | | | | | |
| 8760, | cate be executed physician and the burial-transit | dical Exa | resulting in death) Last | Due to (or as | a consequence of): | | | | | | |
| O. Box 6 | death certifi e attending id for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of Month | | / Day Year |
| S, G | s that ned by e deta | by Ph | Part II. Other significant conditions co | ntributing to death b | ut not resulting in the un | derlying cause give | n in Part I. | 23e. Did tobacc | o use contribut | te to the | cause of death? |
| ords | w requires that been signed b should be deta | | | | | | | 1 🗆 Yes | X XNo 3 □ |] Probab | oly 4 Dunknown |
| I Record | The la ata has page 2 | Completed | | | | | | 24a. Was an autopsy performed 1 Yes 2X | ? prior | to comp h? | y findings available pletion of cause of |
| Vita | Physician: Th this certificata ral director, pag | o Be | 25. Was case referred to medical examiner? | fospital: | | Otho | | (Check only one) | | | |
| on of | Attending Physic death. Botor: After this by the funeral di | ⊢ . | 1 ☐ Yes 2X No ☐ 6 27. Manner of Death 11 Natural 5 ☐ Pending 2 ☐ Accident investigation | 1 ☐ Inpatie 28a. Date of Injui (Month, Day | y 28b. Time of | 28c. Injury Work | at ? | me XXResidence 28d. Describe how in | 6 Other (S | Specify) | |
| Division | spital or Attendi ours after death, leral Diractor; A filled in by the fi | Certification; | 3 Surcide 6 Could not be determined | 28e. Place of Injubulding, etc. | rry - At home, farm, stre c. (Specify) | et, factory, office | | 28f. Location (Street City or Town, St | and Number of ate) | r Rural F | Route Number, |
| | he Hos n 24 h he Fur pletely | Medical | one) | sician: To the best oner: On the basis of and manner sta | of my knowledge, death examination and/or invited. | estigation, in my opi | nion, death occurr | and due to the cause ed at the time, date a | e(s) and manner and place, and | r as state due to th | ed. ne cause(s) |
| | S Wild | - | 29b. Signature and title of certifier | . 1 | 0 | 29c. License | number | 29d. I | Date signed (M | onth, Da | Year) |
| | 5 | | 30. Name and address of person who co | ompleted cause of de | path (Item 23a) (Type, F | Print) JARK | 40118 | Luther | 10V 2 | 3 | 7005 |
| ı | Star Registra | | 31. Date filed (Month, Day, Year) 3 | 0 2005 Registr | s Signature | Spelles | 141 | miner | VIIIC | 1 1 | V +10 15 |

| | | Ple | ase Type | e or l | Print in | Black | Inc | lelible Ink. | Ensure | All Copies | Are | Legible | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------|-----------------------|-----------------------------------------------------------------------------|----------------------------------------------|------------------------------------------|---------------------------|---------------------------|------------------------------------------------------------|--|
| | | For State Registrar | Sta | ite of | Maryla | | | rtment of H | | d Mental Hy | gien | U U U | 38490 | |
| Physicia /Medica | | 1. Decedent's Name (First, Mide Janice | | | | Brow | | | | 2. Date of De Month | ath Da | 26 2005 5:258 | | |
| Examine | | 4a. Facility Name (If not instituti GOOD SAMARI | ETAN | tosi | ETAL | | | | TMORE | | 40 | e. County of Do | | |
| Funeral Director | | 5. Social Security Number 217-54-8885 Usual Residence of Decedent | 6. Sex 1 ☐ M 2 | | 7. Age (In yrs | s. last birtho | 7/ | If Under 1 Year Months Days | If Under 24 H Hours M | | th ay, Year 194 | 9. E 19 Ne | Birthplace (State or Foreign Country) W York | |
| Maryland -f show | tor | 10a. State 10b. Count | y imore | | 10c. C | Ros | | | | | | | 10d. Inside City Limits 1 ★Yes 2 No | |
| n with the | al Director | 10e. Street and Number 6630 Ridget | | Dri | ve | | | 10f. Zip Code 21237 | | | | itizen of What | Country? | |
| 2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other then "naturel", or Items 23e or 28e-1 show eumatic event, the Medical Exertires must be notified. | by Funeral I | 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce | 12. Warried 1 [| | dent Ever in to ces? 2 No | U.S. | lf | 1. | spanic Origin? n, Mexican, Pu Specify: | (Specify Yes or No erto Rican, etc.) | | 14. Race - Ar Black, W | merican Indian, hite, etc. Black | |
| within 72 ho ane. then "natur | Completed | 15. Decede (Specify only high Elementary/Secondary (0-12) | Co | llege (1- | | (C | Give k ife. D | ent's Usual Occupa ind of work done of O NOT use retired | luring most of w) | | | Kind of Busines | | |
| td be filed vental Hygie ked other i ic event, II | lo Be Co | 17. Father's Name (First, Middle | , Last) | 3 years Computer operator U.S 18. Mother's Name (First, Middle, Maiden Sum Audrey Brown | | | | | | | | S.S.F. | & G | |
| permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", any injury or other treumatic event, the Medical Exapone. | | 19a. Informant's Name/Relation Tanielle Kia 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (21. Signature of Funeral Service) | BOOKI 3 □ Remova Specify) 5 Lisensee | nan, | state Zob. | hter Place of D cometery, | 66 lispos crem. | 30 Ridgation (Name of atory or other place) Name and Address ALVIN B 412 E. | eborne so Facility SCRU PRESTO | Date 2,2005 GGS FUN N ST. B | RC 20c. L BC ERA | sedal | e, MD 21237 or Town, State E, MD 21213 | |
| Physician /Medical Examiner | | 23a. Part. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) | a | CE | iused the dea ich line. KEBK f or as a conse | AC A | 1/1× | OXIA | | ac or respiratory a | rrest, | | Approximate Interval Between Onset and Death | |
| executed in and ial-transit | EXB | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | | or as a conse | | | 'N EU MO | NJA | | | | | |
| The law requires that the death certificate be to has been signed by the attending physicia page 2 should be detached for use as the bur | rnysician/medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown | 10 | Live bir | ome of pregn th 2 Fet int at time of o | al déath | | Ectopic pregnancy Other (specify) | | | | 23d. Date of d Month | elivery Day Year | |
| v requires that been signed b should be det | 2 | Part II. Other significant condit | ons contribution | ng to dea | ath but not res | sulting in th | ne und | derlying cause give | n in Part I. | | | | to the cause of death? Probably 4 | |
| | Completed | | | | | | | | | 24a. Was autop perio 1 □ Yes | rmed? | prior to death? | autopsy findings available completion of cause of as 2X No | |
| ysicien: iis certific director, | 0 0 0 | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No | | ^{l:} 1 ⊠ (In | patient 2 |] ER/Outpa | atient | 3□ DOA Othe | | eath <i>Check only o</i> Home 5 Resid | | 6 □Other (Sp | ecify) | |

Examine Division of Vital Records, P.O. Box 68760, Certification; To

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

27. Manner of Death

1 🛮 Natural

2 Accident

3 🗀 Suicide

29a. Certifier (Check only one)

4 - Homicide

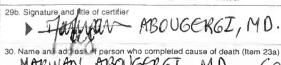
7

Registrar

Medical

5 Pending

investigation 6 Could not be determined



28a. Date of Injury (Month, Day Year)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

RES 000

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

11,26,2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print)

MARWAN ABOUGERGI, M.D. GOOD SAMARITAN HOSPITAC

31. Date filed (Month, Day, Year)

NOV 3 0 2005

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie For State Registrar 38491 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 5:35 PM M Lee T. Barnes November 18, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 933 Western Chapel Road Westminster Carrol1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Oct 27, 19 **Funeral** Birthplace (State or Foreign Country) 1 ₹M 2 □ F Director Yrs. 57 212-50-5227 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Itams 23s or 28a-f show other traumatic event, the Medical Exercitier must be maillised at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 933 Western Chapel Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll County Hospital 200 Memorial Avenue Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö `4 □Donation 5 ₩Other (Specify) in state Sign ture of Funeral Serving Ronal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street S Wade, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Enysician craah arlure /Medical Due to (or as a consequence of): Examiner ancrea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 1 Due to (or as a consequence of): disease Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 3 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death | Director: / d in by the f 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) East Main st Westwinster 2115 DSAM MA 44 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 3 0 2005

Registrar

Separa .

State of Maryland / Department of Health and Mental Hygier [2] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Albert L. Bullis 19, 2005 November 11:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 ☐ F Yrs. Director 213-26-0029 76 Aug 18, 1929 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits , or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1416 S. Old Mountain Road 21085 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours affer 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white à 3 Widowed 4 Divorced 47-50 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 electronic technician ges 1 and 2 should be filed a f of Health and Menfal Hygie If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alonzo Asarah Bullis Verna Claire Holbrook 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bullis/spouse 1416 S. Old Mountain Road Joppa, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatura Euneral Service Ucensee Bin State Anatomy Board 655 W. Baltimore Street more 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate cause (Final **Physician** months disease or condition resulting in death) Metastanz JEST SZI CANCRI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner use as the burial-transif Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ∑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 00No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NZSP(4 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Ceath 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 Navember 20 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAPLIES an 6601 Charles ST BAVEN MD 21204 AMON N 31. Date filed (Month, Day, Year) NOV 3 0 2005 32. Registrar's Signature State The sal Registrar

State Registrar 31. Date filed (Month, Day, Year)

SABCOCK, RICHARD MAXWELL

| | | | for State Registrar | State of Man | | artment of H | | ınd Mer | | iene | 005 | 38 | 494 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------|----------------------------------------|--------------------------------|---------------------------------|------------------------|----------------------------------------|----------------------------------|------------------------------|
| 3 | Planeiei | | 1. Decedent's Name (First, Middle, Last | | | | | | Date of Deat Month | th Day | Year | | ne of Death |
| | Physicia /Medic | | | uchanan | | 41. Oh. T | 1 | | DVEMBI | ER a | 27, 20 | | 3:35FM |
| | Examin | èr | 4a. Facility Name (If not institution, give Saint Joseph | n Medical | | 4b. City, Town, or | | Tows | | | | altin | |
| | Funeral Director | | 5. Social Security Number 6. Sec. 12. 22-8411 | 311 -0- | <i>In yrs. Iast birthd</i> ay) 79 Yrs. | Months Days | Hours | Min. | Date of Birth (Month, Day, | 3, 1 | 926 We | thplace (St ountry) St Vi: | ate or Foreign rginia |
| 5 | ס | | Usual Residence of Decedent 10a. State 10b. County | 10 | Oc. City, Town or Lo | eation | | | | | | | de City Limits |
| | Maryla febo | tor | Md. Baltimore | | Timonium | | | | | | | | Yes 2⊠No |
| | or 28a | irec | 10e. Street and Number | | | 10f. Zip Code | | | 1 | _ | en of What C | ountry? | |
| | 23a | rai | 12110 Tullamore C | | | 21093 | | | | US | | | |
| 36 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow or other traumatic event, the Medical Exaciliar front for Indilliad at | y Funeral Director | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Eve Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates: | 1 | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No | spanic Orig n, Mexican, Specify: | gin? (Specify , Puerto Rica | y Yes or No- an, etc.) | | 4. Race - Am Black, Whi Specify: | | |
| 9-0 | 72 hou | Completed by | 15. Decedent's Edu (Specify only highest grad | cation | 16a. Dece | dent's Usual Occupa | ation | of working | | 16b. Kin | d of Business | /Industry | |
| 121 | within 7 ene. than "r | mple | Elementary/Secondary (0-12) | College (1-4or 5+) | Homen | kind of work done a DO NOT use retired, |) | GI WOIKING | | Dι | un Home | _ | |
| d 2. | e filed within al Hygiene. other than | | 12 17. Father's Name (First, Middle, Last) | 77 | Rulliell | ligker. | 18. Mother | r's Name (F | irst, Middle, I | | | | |
| /lan | should be nd Mental marked o | To Be | William Jordan No | orman | | | He] | len Au | igusta | Loar | ne | | |
| Maryland 21215-0036 | 12 sho h and 7 is mu traum | | 19a. Informant's Name/Relationship (T) Judge William R. I | | | ng Address <i>(Street a</i> D Tullamo | | | | - | | | 21093 |
| ē, | s 1 and f Health Item 27 other tr | | 20a. Method of Disposition | | - 4 | sition (Name of matory or other place | | Date | - | | ation - City or | | |
| OE . | Page: nent of int: if i | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | Temoval Holli State | | | | 2-2-0 | 5 | T | Lmoniur | n, Md. | |
| Baltimore, | permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once. | | 21. Signature of Fureral Cervice Licens | | | Name and Address Ruck Tows | s of Facility | uneral | . Home, | Inc | 3 . | | |
| . 3. | 20260 | | 23a. Part 1. Enter the disease, or comp | ications that caused the | e death. Do not ent | 1050 York | k Rd. | Towsc | n, Md. | 213 | 204 | Approx | imate |
| | Physician | | shock, or heart failure. List only o Immediate Cause (Final disease or condition | ne cause on each line. SEPSIS | | , | | | | | | | l Between and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a c | onsequence of): | TO THE A. A STAN OFFIN AND MADE | | | | | | | |
| | Examiner | 76 | Sequentially list conditions, | b. Due to (or as a c | | INFECT | TON | | | | | | |
| | uted d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | c | | | | | | | | | |
| 0, | icate be executed physician and s the burial-transit | | resulting in death) Last | Due to (or as a c | onsequence of): | | | | | | | | |
| 8760, | icate b physic s the bi | edical | | d | | | | | | | - | | |
| Вох 6 | death certifica attending ph d for use as the | n/Me | IF FEMALE: 23b, Was decedent pregnant | 23c. If yes, outcome of p | | | | | | 23 | 3d. Date of de | livery | |
| Ö | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1□Live birth 2□ 4□Pregnant at tim 9□Unknown | | Ectopic pregnancy Other (specify) | | | | | Month | Day | Year |
| s, P | es that igned b be deta | by PI | Part II. Other significant conditions co | | not resulting in the u | nderlying cause give | en in Part I, | | | | e contribute t | | |
| ord | v requir been si should | eted | ACUTE RENAL FAIL | <u>_URE</u> | | | | | 1 □ Ye | | No 3 □ P | robably 4 | 4 □Unknown |
| Records, | The law ate has b page 2 s | Completed | | | | | | _ | 24a. Was a autops perforr | y ned? | prior to death? | completion | ngs available of cause of |
| Vital | sician: T certificat rector, pa | 0 | 25. Was case referred to medical | | | | 26. Place | of Death (C | 1 ☐ Yes 2 Theck only on | e) | 1 🗌 Yes | 2 2 No | |
| of V | Physician: r this certificanal director, is | ToB | TU Tes 200 No | Hospital: 1 Inpatient | 2 ER/Outpatier | | 4 🗆 INUI | | | | Other (Spe | ecity) | |
| | ding P h. After funera | tion | 27. Many of Death 1 | 28a. Date of Injury (Month, Day Y | (ear) 28b. Time o | Work | ∕at ⟨? Yes 2∐N | | . Describe ho | w injury | occurred | | |
| Division | I or Attending after death. Director: After | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. (| · At home, farm, str (Specify) | reet, factory, office | | 28f. | Location (St. City or Town | | Number or R | ural Route | Number, |
| _ | To the Hospital or within 24 hours after To the Funeral Director completely filled in b. | Medical Ce | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam | rsician: To the best of niner: On the basis of ex | camination and/or in | h occurred at the tim vestigation, in my op | ne, date and pinion, deat | d place, and th occurred a | due to the ca | ause(s) a ate and p | nd manner a place, and du | s stated. e to the cau | J5e(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier | 1 | | 29c. License | number | | 2 | 9d. Date | signed (Mon | th, Day, Ye | ar) |
| | 15 | 2 |) (K | ws | | DE | 7254 | | | 11 (| 27/ | 05 | |
| ľ | 1 | | 30. Name and address of person who c | | | | Limen | to at you see | 15.73 29.2 | | and along a | | |
| 1 | Sta | ite | 31. Date filed (Month-Day, Year) | 32. Resistrar's | Cinnoluse | RIVE TO | WSUN, | " LAIN-3 FA | YLHNI | 2 = 1 | <u>=144</u> | | |
| | Regist | rar | NOV 3 0 2 | 2005 Maleus | J. J. A. | serle) | | | | | | | |

| · | 1 - For State Registrar | State of Maryland / De | partment of Health and ertificate of Death | Mental Hygie | 9 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------|
| Physician /Medica | al | еу | 4b. City, Town, or Location of Dea | 2. Date of Death Month November | |
| Examine Funeral Director | 114 Church Stree 5. Social Security Number 6. Se | et | Westminster | 8. Date of Birth | 4c. County of Death Carroll 9. Birthplace (State or Fore Country) Md |
| within 72 hours after death with the Maryland ane. then "natural" or items 23e or 28e-f show for Modical Examinat must be notified at | 10a. State 10b. County | 10c. City, Town or Westm | inster | | 10d. Inside City Lim 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
| ns 23a or | Md Carroll 10e. Street and Number 114 Church Street 11. Marital Status 1 Never Married 2 Married | | 10f. Zip Code 21157 Was Decedent of Hispanic Origin? (5) | U | SA 14. Race - American Indian, |
| be filed within 72 hours after death with the Marylan tal Hygiane. ed other then "natural", or items 23a or 28a-f show event, the Medical Examirat must be notified at | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give \(\hat{\Lambda} \) Year or Dates: | Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer | to Rican, etc.) | Black, White, etc. Specify: white |
| within /c. lane. then "nat | 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12 | College (1-4or 5+) | cedent's Usual Occupation ye kind of work done during most of wo . DO NOT use retired) Onstruction worker | rking | b. Kind of Business/Industry COnstruction |
| incuid be lied of Mental Hygis marked other matic event, if | 17. Father's Name (First, Middle, Last) Lawrence Bosley | | | me (First, Middle, Ma. | |
| Heelth and I | 19a. Informant's Name/Relationship (T | use) 114 | iling Address (Street and Number or Pi Church St., Westmi | nster, Md | 21157 |
| perimi. Tages I and 2 stodius perimi. Pages I and 2 stodius began the periminal of the periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal periminal | 20a. Method of Disposition 1 X Burial 2 Cremation 3 If 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens | Lake Vi | position (Name of ematory or other place) EW Memorial 11-2 22. Name and Address of Facility Ha | 9-05 Sy | c. Location - City or Town, State ykesville, Md |
| | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d. | COLON C | 4 | Approximate Injerval Between Onset and Death |
| page 2 should be detached for use as the | IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 | | □Ectopic pregnancy □ Other (specify) | | 23d. Date of delivery Month Day Year |
| ු ලිසි | | ntributing to death but not resulting in the | underlying cause given in Part I. | DI - | co use contribute to the cause of death? |
| is certificate hes been s director, page 2 should | | | | 24a. Was an autopsy performed 1 ☐ Yes 2 € | |
| After th funeral | examiner? | Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time Injury | ent 3 DOA Other: 4 Nursing H | ome 5 Aesidence 28d. Describe how i | e 6 ☐Other (Specify) |
| nospitel or Attendang report by the formal placetor; After tely filled in by the funeral lines of the formal placetor; | | 28e. Place of Injury - At home, farm, s building, etc. (Specify) | | City or Town, S | |
| within 24 hours after deal To the Funeral Director: completely filled in by the | 29a. Certifier 1 Certifyin; Physical Exami (Check only 2 Medical Exami one) 29b. Signature and title of cetifier | sician: To the best of my knowledge dea ner: On the basis of examination and/or and manner stated. | ith occurrad at the time, date and place nvestigation, in my opinion, death occu 29c. License number | rred at the time, date | and place, and due to the cause(s) Date signed (Month, Day, Year) |
| 1 | 30. Name and address of person who co | empleted cause of death (Item 23a) (Type | D3539& | 11 | -26-05 |
|) | FLAVIO KEUTER | 555 S.CEN | THER ST WESTI | SIZIZNI L | MD 21157 |

| homas | -0036 |
|---------|---------------|
| olm, T. | and 21215-003 |
| hish | e, Maryland |
| 0 | Baltimore |

| | | | 1 - For State Registrar | State of Maryl | | epartment of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont | | | giene Reg. No. 0 5 | 38496 |
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| | Physici /Medic | | 1. Decedent's Name (First, Middle, Las | Thomas Ree | ce Chi | sholm, Jr. | | 2. Date of Dea | Day Ye | ar 3. Time of Death |
| - | Examin Funeral Director | | 244-70-6243 | Hospital Cen | Her yrs. last birtho Yr | RODE(| If Under 24 Hrs | th 8. Date of Birtl | 4c. County of E | Death |
| | Aaryland I ehow | ō | Usual Residence of Decedent 10a. State 10b. County Maryland Bal | timore 10c | . City, Town o | | ddle Rive | er | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ 🖏o |
| | death with the Maryland me 23s or 28e-f ehow rinner to mulfied at | Director | 10e. Street and Number 28 Elm Drive | | | 10f. Zip Code | 21220 | | 10g. Citizen of Wha | t Country? |
| 0000 | be filed within 72 hours after death with the Marylan at all typiene. All typiene. All typiene. All the Medical Examiner must be nutified at a vent. | by Funeral | 11. Marital Status 1 Never Married **Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | in U.S. | 13. Was Decedent of H If Yes, specify Cub | Hispanic Origin? (S | Specify Yes or No- to Rican, etc.) | 14. Race - A | American Indian, Vhite, etc. White |
| N-0121 | be filed within 72 hours after ital Hygiene. Id other than "natural", or ite event, the Medical Examene | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) | ucation de completed) College (1-4or 5+) | 16a. D | ecedent's Usual Occup Give kind of work done fe. DO NOT use retire | pation during most of wo d) | rking | 16b. Kind of Busine | ess/Industry |
| ומווח ע | 2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event. Ins M. | To Be Co | 12 Years 17. Father's Name (First, Middle, Last) Thomas Reece Ch | isholm, Sr. | | Laborer | | | Maiden Sumame) Le Wyrick | l Industry |
| , Mai y | s 1 and 2 should Influent and Menical Item 27 is marked other traumatic | | 19a. Informant's Name/Relationship (7) Mrs. Judith C. (| ype, Print) Wife | | Mailing Address (Street Elm Drive | and Number or Ri | | r, City or Town, Star | te, <i>Zip Code)</i> 21220 |
| | Page nent c snt: if ury or | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify) | Removal from State | cemetery, | isposition (Name of crematory or other pla Hill Mem. (| Gdns. 11, | | | River, MD |
| מ | permit. Departr importr eny inje | | 21. Signature of Funeral Service Licens |) | | 22. Name and Addre Duda-Ruck 7922 Wise | Ave. D | undalk, | Maryland | 21222 |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) | a. Meta 3+ Due to (or as a con | afic | Lung Co | ng, such as cardia | c or respiratory arr | rest, | Approximate Interval Between Onset and Death 7 months |
| ,0070 | tificate be executed g physicien and as the burial-transit | edical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a con Due to (or as a con Due to (or as a con | | | | | | |
| .O. BOX 00 | w requires thet the death certific been signed by the attending pl should be detached for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown | etal death | 3 □Ectopic pregnanc; 5 □ Other (specify) □ | у | | 23d. Date of Month | delivery Day Year |
| L (00) | quires thet en signed b | by | Part II. Other significant conditions co | ntributing to death but not | resulting in th | e underlying cause giv | ven in Part I. | | | e to the cause of death? Probably 4 Dunknown |
| מו חמני | : The law re icete has be | Completed | | | | | | 24a. Was a autops perform | sy prior | |
| NA IO IIOISIA | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funneria Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. | Certification: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined | - dospital: 28a. Date of Injury (Month, Day Year 28e. Place of Injury - A | 28b. Tim Inju | e of 28c. Injur | ler: 4 ☐ Nursing H | 28d. Describe ho | ence 6 Other (Sow injury occurred | Specify) - Rural Route Number, |
| 2 | Hospital or 4 hours after Funerel Dir ely filled in | edical Cert | 29a. Certifier 1 Certifying Phy | building, etc. (Sp sicien: To the best of my ner: On the basis of exam | knowledge d | eath occurred at the tir | me, date and place | city or Town | auso(s) and manna | r as stated. |
| | To the To the Complet | Med | one) 29b. Signature and title of certifier | and manner stated. | D . | 29c. Licens | e number 45390 |) (| 9d. Date signed (Michigan | onth, Day, Year) |
| (| 81 | | 30. Name and address of erson who come to the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of th | ompleted cause of death (| Item 23a) (Ty | pe. Print) | ad #2 | S, Ball | finiore | MD21236 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registrar's Si | | Scorts | | | | |

| | | | for State Registrar | | State of M | aryland / I | | irtment of F tificate of | Health and N <i>Death</i> | Mental Hy | 'gle¶eU Reg. No. | 03 | 38491 |
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| 100 | Dhysia | 7 1 | 1. Decedent's Name (First, I | Aiddle, Las | t) | | | | | 2. Date of De | eath Day | Vaar | 3. Time of Death |
| | Physici /Medi | | Edna Elizab | eth C | Cooney | | | | | Noven | ber 2 | 3 280 | \$ 12:00 AM |
| | Examir | ier | 4a. Facility Name (If not insti | | | | | 4b. City, Town, o | or Location of Death | | 4c. Co | unty of Death | 1 |
| | | or in | Baltimore Wa | | | | | Glen Bur | | | | e Arun | |
| 8 | Funeral Director | | 5. Social Security Number 216-24-8994 Usual Residence of Decede | | M 2⊠F 7. A | ge (In yrs. last bii 92 | Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bit 3/9/19 | 13 (ear) | 9. Birth Balt | place (State or Foreign intry) IMOTE |
| | yland | | 10a. State 10b. Co | | | 10c. City, Tow | n or Lo | cation | | | | | 10d. Inside City Limits |
| | 8a-fs | Director | MD n/ | а | | Ba1 | timo | ore | | | | | 1⊠Yes 2□No |
| | vith th | Dire | 10e. Street and Number | | | | | 10f. Zip Code | | | 10g. Citizen | of What Cou | ntry? |
| | s 23e | a | 3685 MacTav | ish A | | F | 10.1 | 21229 | | | | ted St | |
| Maryland 21215-0036 | s within 72 hours after death with the Maryland Jione rithsn "natural", or Itams 23a or 28s-1 show the Medical Examinar must be notified at | d by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo | | 12. Was Decedent Armed Forces 1 ☐ Yes 2 弦 If Yes, Give Year or Dates: | | | Vas Decedent of h Yes, specify Cub | dispanic Origin? (Sp an, Mexican, Puerto Specify: | pecify Yes or No Rican, etc.) | | Race - Ameri Black, White, ^{ecify:} Whi | , etc. |
| 5-0 | 72 h | etec | 15. Dec (Specify only h | edent's Edi | ucation de completed) | 16a. | Deced (Give | ent's Usual Occup kind of work done | oation during most of work d) | king | 16b. Kind o | ol Business/In | ndustry |
| 121 | within ene. then | Completed | Elementary/Secondary (0- | 12) | College (1-4or | 5+) | | | | | Retai | ll Clot | thina |
| 9 | Hys The | Be C | 17. Father's Name (First, Mic | ddle, Last) | | | зат | es Woman | 18. Mother's Nam | e (First, Middle | | | -IIIIIg |
| lan | \$ 0 ° 0 | To B | Carl Christ | ian M | oerken | | | | Kathryn | Elizab | eth Pa | rrish | |
| ary | 2 should and Mer is marks eumatic | 0 | 19a. Informant's Name/Rela | tionship (T | ype, Print) | 196 | Mailin | g Address (Street | and Number or Rui | | | | Code) |
| | and and m 27 | ١., | S. Catherine | Ship | ley / dau | | | | w Drive C | | | | |
| Baltimore, | permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic 805e. | 0 | 20a. Method of Disposition 1 △ Burial 2 □ Crema 4 □ Donation 5 □ Oth | tion 3 🗆 I er <i>(Specify</i> , | Removal from State | New Ca | y, crem athe | | etery 11, | | Balta | | Maryland |
| Balt | permit. Departr Importa any inji | | 21. Signatule of Furreral Sel | vice Licens | DO | but | 13 | Name and Address 28 Sulph | ss of Facility Amb ur Spring | orose Fu g Rd Art | neral | Home, Maryla | Inc. and 21227 |
| | Physician /Medical Examiner | 369 350 | 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) | e, or comp List only o | a Chron | the death. Do no. | tru | er the mode of dyir | | or respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA | | iner | Sugaritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Į | Due to (or as | a consequence | of): | | | | | | |
| 60, | tificate be executed ig physicien and as the burial-transit | ai Examiner | that initiated events resulting in death) Last | | c Due to (or as | a consequence | of): | | | | | | |
| 68760, | ficate phys s the | edicai | | | d | | | | | | | 100 | |
| .O. Box (| The law requires that the death certifie has been signed by the attending tage 2 should be detached for use a | Physician/Me | IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown | t | 23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown | 2 Fetal death | | Ectopic pregnancy Other (specify) | / | | | Date of delive Month | ery Day Year |
| 0 | w requires that been signed b should be deta | by | Part II. Other significant cor | iditions co | ntributing to death b | ut not resulting in | the un | derlying cause giv | en in Part I. | | | contribute to the | he cause of death? |
| Vital Records, | | Completed | | | | | | | | | | prior to con death? | psy findings available impletion of cause of 2 D No |
| | Physicien: this certificaral director, p | o Be | 25. Was case referred to me examiner? 1 Yes 2 No | | Hospital: | ent 2□ER/Ou | Ingliant | 3□ DOA Oth | er: | | 7.1. | | |
| of | g Phys er this eral di | - | 27. Mann of Death | - | 28a. Date of Inju (Month, Da | | ime of | 28c. Injur | 4 Nursing no | 28d. Describe h | | | v) |
| ion | Attending F r death. ector: After i | atio | 1 Natural 5 Pe | ending restigation | (Month, Da | y rear) II | njury | | K? Yes 2 □ No | | | | |
| Division | tel or Attend s after death el Director: , ed in by the f | Certification: | | ould not be termined | 28e. Place of Inj building, et | ury - At home, fa c. (Specify) | rm, stre | et, factory, office | | 28f. Location (S City or Tox | Street and Nu vn, State) | mber or Rura | al Route Number, |
| | To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by | edical | 29a. Certifier 1 Cert (Check only 2 Med one) | ifying Phy ical Exami | sician: To the best iner: On the basis o and manner st | examination and | death | estigation, in my o | pinion, death occur | and due to the red at the time, | cause(s) and date and plac | manner as st | lated. the cause(s) |
| | To the within 2 To the complet | ▼ | 29b. Signature and title of ce | | Nich | M M.D. | | 29c. Licens | e number (365 | / | 29d. Date sig | med (Month, | Day, Year) 2005 |
| | 0 | | 30. Name and address of pe | | ompleted cause of d | eath (Item 23a) (| 301 | Hospita | d Drive | e, Gler | Bui | rnie, t | 1D. 2106 |
| | Sta Registr | ar | 31. Date filed (Month, Day, Y | | 005 32. Pagistr | ar's Signature | 4 | and | | | | | |
| DH | MH 17 Rev 1/20 | 001 | | | | | 9 | | | | | | |

Cooney, Edna

| | | | For Stata Registrar | State of N | Marylan | | | of H | ealth a | | lental Hyg | jiene jeg. No. | 005 | 384 | 98 |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------|-------------------------------------------------|---------------------------------------------------|--------------------------------------------|--------------|-----------------------|-------------------------------------|-----------------------|--------------------------------|-----------------------------------|--------------------|
| | hysicia /Medic | al | Decedent's Name (First, Middle, L. Brenda J. Aa. Facility Name (If not institution, gi | Clark | 1 | | Ab City T | | Location o | | 2. Date of Dea Month November | Day 28, | | 3. Time of 6:20 | |
| Fu | xamin ineral rector | E1 | 6340 Spring Wat 5. Social Security Number 6. | er Terrac | e Uni | t [, last birthday) Yrs. | Fr | eder | | | 8. Date of Birth | Fr | rederi 9. Birth Wash | | Foreign DC |
| the Maryland | 28a-f show notified at | rector | Usual Residence of Decedent 10a. State 10b. County Maryland Frederi 10e. Street and Number | ck | 10c. Cit | y, Town or Lo | lerick | | | | | Oa. Citizen | of What Cou | 10d. Inside City 1 ☐ Yes | • |
| -0036 hours after death with the Maryland | marked other than "natural", or Itams 23a or 28a-f show matic evant. It's Medical Examinat must be notified at | by Funeral Director | 6340 Spring Wate 11. Marital Status 1 (Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decede Armed Force 1 | nt Ever in U. s? MiNo | .S. 13. | | 2170 ent of His ify Cubar | | gin? (Spe , Puerto | ecify Yes or No- Rican, etc.) | U . | S.A. Race - Amer Black, White | ican Indian, , etc. | |
| 21215 d within 72 glene. | ier than "natural t. It e Medical Ex | Completed | 15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) | ducation ade completed) College (1-4d | | 16a. Dece (Give life. | dent's Usual kind of work DO NOT use 1ed | l Occupa k do <i>ne d</i> e retired) | uring most | | | N/ | | ndustry | |
| Maryland d 2 should be file th and Mental Hy | s markad oth umatic evan | To Be | 17. Father's Name (First, Middle, Las Coyal Clark19a. Informant's Name/Relationship | (Type, Print) | | | | | A1: | ice l | Mae Russ | sell r, City or To | wn, State, Zi | | |
| Baltimore, Mi Demit. Pages 1 and 2 Department of Health 8 | Important: If itam 27 is marka any injury or othar traumatic once. | 1. | Randy Irvine (fia 20a. Method of Disposition 1♥ Burial 2 □ Cremation 3 ('4 □ Donation 5 □ Other (Spec | ☐Removal from Sta | 20b. P | 634 Place of Dispo emetery, cred ar Hi | sition (Nam | e of | 1 | ec. | | 20c. Locati | on - City or T | | |
| Baltim permit. Pag Department | Importa any inju once. | | 21. Sign tu a of Funeral Service Lice 23a Part 1. Enter the disease, or cor shock, or heart failure. List only | nsee <u>moo</u> | 257 sed the death | 6 | | ld A | lexar | ndria | e Funera a Ferry | ROad | | on, MD2 Approximate Interval Betw | veen |
| 3760, A secuted ate be executed | physician and disconnections and street street and street street and street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street str | dical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to amount a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or c | as a conseq | uence of):) | arti | 200 | l of |)16 Nu | C958 | | | Onset and D | eam |
| .O. BOX 6 | ittending or use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown | 23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown | 2 Feta at time of d | I death 3□ | Ectopic pre Other (spe | | | | | 23d. | Date of delive | | ear |
| Records, P.O. The law requires that the | should be detached the a | by | Part II. Other significant conditions | contributing to death | but not res | ulting in the u | nderlying ca | use give | n in Part I. | | 23e. Did tol | | _ | the cause of de | |
| | this certificate has b ral director, page 2 st | Be Completed | 25. Was case referred to medical | | - | | | | 26. Place | of Death | 24a. Was a autops perform 1 Yes 2 | iy ned? 2 ☑ No | prior to co death? | opsy findings a ompletion of ca | vailable use of |
| E gui | After | 2 | examiner? 1 Yes 2 To 27. Manner Death 1 Natural 5 Pending 2 Accident investigation | | | ER/Outpatier 28b. Time of Injury | | lc. Injury Work | r: 4 🗆 Nur | sing Hor | ne 5 L eside 28d. Describe ho | ence 6 🗌 | | fy) | |
| DIVIS pital or Atta | aral Director: , filled in by the f | I Certification: | 3 Suicide 4 Homicide Could not determined | 280. Place of | etc. (Specify | y) | | | - dete ess | | 28f. Location (St City or Town | n, State) | | | er, |
| To the Hospital within 24 hours | To the Funaral completely filled | Medical | (Check only one) 2 Medical Exa 29b. Signature and title of certifier | miner: On the basis and manner | of examina | tion and/or in | vestigation, | in my op | inion, deat | h occurre | ed at the time, d | ate and plac | gned (Month, | o the cause(s) | |
| | 2 | | 30. Name and address of person who | completed cause o | f death (Item | 23a) (Type, | | | 354 | | | 11 | 129 | 105 | 1 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 3 0 | 2005 32. Figi | strar's Signa | iture A | and i | 110 | | 40 | Jhman | She | ane o | red | undy |

| | | | 1 - For State Registrar | State of Mary | | artment of F | | | iene | 38499 |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------|---------------------------------------|-------------------------------------------------------------------------|
| | Physici /Medi Examir | cal | 1. Decedent's Name (First, Middle, Las. An Huyy De A 4a. Facility Name (If nbt institution, give | rgelo | | 4b. City, Town, o | r Location of Deatl | 2. Date of Deat Month | Day Y | 3. Time of Death 3. 45 PM Death |
| | Funeral Director | | 210 20 2237 | | yrs. last birthday) | Bulf If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | (Month, Day, | N/ Year) 3,1931 | /A 3. Birthplace (State or Foreign Country) Maryland |
| | he Maryłand 28a-f ehow cultied et | ector | Usual Residence of Decedent 10a. State 10b. County Maryland Harford | | c. City, Town or Lo | Bel | Air | | | 10d. Inside City Limits 1 Ø Yes 2 □ No |
| | th with t | ai Dir | 10e. Street and Number 601 H Thames Way | | | 10f. Zip Code | 21014 | 10 | Og. Citizen of Wh | - |
| 920 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28s-f ehow other traumatic event, Itle Moutal Exprintmer must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Amed Forces? 1 XYes 2 NO If Yes, Give Year or Dates | | Was Decedent of H If Yes, specify Cuba 1 Yes 2 No | lispanic Origin? (S an, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | Black, | American Indian, White, etc. White |
| 21215-0036 | filed within 72 he Hygiene. Ither then "natusel", Ine M. Clean | Completed | 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 8th Grade | cation | 16a. Dece (Give life. | dent's Usual Occup kind of work done DO NOT use retired | during most of wor d) | king | Baltimor | , |
| Maryland | 2 should be file and Mental Hy, is marked oth aumatic event, | To Be C | 17. Father's Name (First, Middle, Last) Aldorino Angelor | ntonio | | , | Doris | | cci | |
| | nd 2 shallth and 27 is m | | 19a. Informant's Name/Relationship (T) Mrs. Josephine Def | | | | | ral Route Number, 2 Air, MD | | ate, Zip Code) |
| lore, | Pages 1 and intention of Health int: If Item 27 iry or other tr | | 20a. Method of Disposition 1 | Removal from State | Ob. Place of Dispo cemetery, crea | sition (Name of matory or other place | :e) | Date 2 | 0c. Location - Ci | ty or Town, State |
| Baltimore, | permit. Pages Department of Important: If It any injury or once. | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | 22 | 2. Name and Addres | ss of Facility Sc | 0/2005 himunek i Baltimore | Funeral | |
| | Fnysician /Medical Examiner | iner | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate taxes. Enter underlying Cause (Disease or injury) | ications that caused the ne cause on each line. Due to (or as a coron b. Due to (or as a coron b.) | nsequence of): | er the mode of dyin | | or respiratory arre | st, | Approximate Interval Between Onset and Death |
| ,8760, | icate be executed physicien and s the burial-transit | dical Examiner | Cause (Disease of Injury that initiated events resulting in death) Last | c. Due to (or as a cor | nsequence of): | | | | | |
| P.O. Box 6 | The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown | Fetal death 3 ☐ | Ectopic pregnancy Other (specify) | | | 23d. Date o Month | |
| ords, P. | n requires that been signed b should be deta | by | Part II. Other significant conditions co. | ntributing to death but not | t resulting in the u | nderlying cause give | en in Part I. | 23e. Did toba | | ute to the cause of death? |
| | | 3e Completed | 25. Was case referred to medical | | | | 26. Place of Dea | 24a. Was an autopsy perform 1 Yes 2 | ed2 prio dea No 1□ | re autopsy findings available in to completion of cause of th? Yes 2 No |
| of V | Phys this al di | To B | examiner? 1 □ Yes 2 No | The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon | 2 ER/Outpatien | | or: 4 ☐ Nursing H | ome 5 Resider | nce 6 Other | (Specify) |
| | ding h. After fune | ation | 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Yea | 28b. Time of Injury | Work | y at ⟨? Yes 2 □ No | 28d. Describe how | v injury occurred | |
| Division | | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - building, etc. (Sp. | At home, farm, streecify) | eet, factory, office | | 28f. Location (Stre City or Town, | et and Number of State) | or Rural Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical (| 29a. Certifier (Check only one) Certifying Phy | sician: To the best of my ner: On the basis of exar and manner stated. | knowledge, death nination and/or inv | occurred at the time restigation, in my op | ne, date and place, pinion, death occur | and due to the car red at the time, dat | use(s) and manne te and place, and | er as stated. If due to the cause(s) |
| | To the P | Me | 29b. Signature and title of certifier | | | 29c. License | number | 29 | d. Date signed (A | Month, Day, Year) |
| 1 | M | 2 | 30. and a person who co | empleted cause of death | (Item 23a) (Type. | Print) | 5817 | N | vanthe | 26, 2005 |
| | Sta Registr | | Zon: Ching W 31. Date filed (Month, Day, Year) | 32. Registre's S | 2 South | - Green | e Stree | + Bal | to MD | 26, 2005 21201 |

| | | - | For State Registrar | State o | f Marylar | | artment rtificate | | | and M | - | giene Reg.20. | 005 | 38500 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------|---------------------------------------|----------------------------------------|-----------------------|--------------------------|--------------------|---------------|------------|--------------------------|------------------|--------------------------------------------------|-----------------------------------------|
| | Physicia | | Decedent's Name (First, Middle, | • | | | | | | | 2. Date of Dea Month | ath Day | Year | 3. Time of Death 9:00 A _M |
| | /Medic | al | | lle Agnes | | ein | 45 05. 3 | | | | Novembe | 1 | 3, 2005 | 9:00 AM |
| | Examin | er | 4a. Facility Name (If not institution, | | | | | | Location o | of Death | | 40.0 | County of Death | |
| | Funeral | | Genesis Heritage 5. Social Security Number 6 | Sex Merial | 7. Age (In yrs. | last birthday) | If Under | | If Under | | 8. Date of Birt | h | Baltim 9. Birth | ore place (State or Foreign ntry) |
| | Director | | 214-44-3750 | 1□ M 2√□ F | 86 | Yrs. | Months | Days | Hours | Min. | (Month, Da May 20 | | - 1 | york |
| | pu » | | Usual Residence of Decedent 10a. State 10b. County | | 10c C | ty. Town or Lo | partion | | | | | | | 10d. Inside City Limits |
| | faryla shov | ō | , | | 100.01 | ity, Town of Lo | Cation | | | | | | | 1 ☐ Yes 2√€ No |
| | the N 28a-1 | Director | Maryland Ba. 10e. Street and Number | Ltimore | | | 10f. Zip | Code | | Dun | dalk | 10g. Citiz | en of What Cou | ntry? |
| | 3a or | | 204 Ashwood Ro | nad | | | | | 212 | 22 | | - | ted Sta | |
| | death ms 2 | Funeral | 11. Marital Status | | edent Ever in U | J.S. 13. | Was Deced | lent of Hi | ispanic Ori | gin? (Spe | ecify Yes or No- | | 4. Race - Ameri Black, White, | can Indian, |
| 9 | or Ite | Fu | 1 Never Married 2 Married | | 2 Ŋ No | | 1 ☐ Yes 2 | | Specify: | i, i dono | noun, etc./ | | Specify: | etc. |
| 21215-0036 | 72 hours after death with the Maryland natural; or Items 23e or 28e-f show dical Examinat must be notified at | d by | 3 ☑ Widowed 4 □ Divorced | Year or D | ates: | | dent's Usua | | ation | | | | W. nd of Business/In | hite |
| 5 | in 72 in mail realic | Completed | 15. Decedent's (Specify only highest | grade completed) | | (Give | kind of wor DO NOT us | k done d | during mos | t of worki | ng | TOD, KIII | id of business/in | idustry |
| 212 | yiene. | m o | Elementary/Secondary (0-12) 11 Years | College (| 1-40r 5+) | Rest | aurar | at C | ook | | | R | estaura | nt |
| 힏 | e file al Hyg I otha vent, | Be C | 17. Father's Name (First, Middle, La | st) | | | | | 18. Mothe | r's Name | (First, Middle, | Maiden S | Sumame) | |
| Maryland | Ment Ment arkac | 2 | Ernest Miller | <u>-</u> | | | | | | | Adams | | | |
| Jar | 2 shot and is m | | 19a. Informant's Name/Relationship | | . ~h+ ~ ~ \ | | - | | | | | | Town, State, Zip Maryl | · · |
| e, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene. Depar | - | Mrs. Donna Scl | nuize (Dat | | Place of Dispo | | | PDT TU | _ | ad Dui. | | cation - City or T | |
| Baltimore, | ages nt of th | | 1 ☑ Burial 2 ☐ Cremation 3 | | State | cemetery, crei | natory or ot | ther plac | | | | | | |
| Ħ | artme ortani injury | | * 4 □ Donation 5 □ Other (Spe 21. Signature of Juneral Service Li | | Ga | | F'ores | | | | 12/1/20 | 105 | Owings | Mills, MD |
| Ba | Depa Impo any ir | | A sodon | EK | eed | D1 | ıda-Ru | ick : | Funer | al H | ome of dalk, M | Dund | lalk, In | c. 222 |
| | | | 23a. Part1. Enter the disease, or conshock, or heart failure. List or | omplications that only one cause on e | caused the dea | | | | | | | | and 21 | Approximate Interval Between |
| B | Pnysician | | Immediate Cause (Final disease or condition | ME | 加くた | | | | | | CER | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to | (or as a conse | | | | | | | | | 7,77 |
| | Examiner | L | Sequentially list conditions, if any, leading to immediate | b | (| | | | | | | | | |
| | tad nsit | nine | cause. Errer Universitying Cause (Disease or injury | D09 to | (or as a conse | quence oi): | | | | | | | | |
| | al-tra | Examine | that initiated events resulting in death) Last | cDue to | (or as a conse | quence of): | | | | | | | | |
| 8760, | cate be executad obysician and the burial-transit | | | d | | | | | | | | | | |
| 9 | tificate ng phys as the | Physician/Medicai | ICCC III | | | | | | | | | | | |
| Вох | death certific e attending p id for use as t | an/h | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | tcome of pregn birth 2 - Fet | | Ectopic pre | egnancy | | | | 2: | 3d. Date of deliv | ery Day Year |
| О. Е | the dea by the at achad fo | /sici | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregi 9□Unkn | nant at time of lown | death 5 | Other (spe | ecify) | | | | | MONTH | Day Foat |
| 9. | ± > 2 | | Part II. Other significant condition | s contributing to d | leath but not re | sulting in the u | nderlying ca | ause aive | en in Part I. | | 23e. Did to | obacco us | se contribute to t | he cause of death? |
| ds, | Se Ge | d by | | 5 | | · · | , , | ŭ | | | 101 | /es 2□ | No 3□Prol | pably 4 Whiknown |
| COL | > 40 00 | iete | | | | | | | | | 24a. Was | an | 24b. Were auto | opsy findings available |
| Re | 0 5 0 | ompieted | | | | | | | | | | rmed? | prior to co death? 1 \(\sum \text{Yes} \) | mpletion of cause of |
| ita | sician: Th certificate rector, pag | Se C | 25. Was case referred to medical | | | | | | 26. Place | of Death | 1 ☐ Yes (Check only o | 2 4. 146 | 10 103 | 200110 |
| of Vital Records, | di ib | To B | examiner? 1 ☐ Yes 2 ☑ No | | | ER/Outpatier | nt 3□ DO | Othe | er: 4 | rsing Hor | ne 5□Resid | dence 6 | □Other (Specia | (y) |
| o C | | | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending | 28a. Date (Mon | of Injury oth, Day Year) | 28b. Time o Injury | | 8c. Injury Work | | | 28d. Describe t | now injury | occurred | |
| isio | teat tor: tha | icat | 2 Accident investigated in Suicide 6 Could not | t be | o of Injury - At t | nome form et | M | | Yes 2 □ | - | 28f Location /9 | Stroot and | Number or Pur | al Route Number. |
| Division | l or Atten after deat Diractor: in by tha | ertification; | 4 ☐ Homicide determin | ed 289. Flack build | e of Injury - At t ling, etc. (Spec | ify) | eet, factory | , office | | ľ | City or Tox | | I NUMBER OF HUIS | ar noute Number, |
| | To the Hospital or Al within 24 hours after of To tha Funeral Dirac completely filled in by | O | 29a. Certifier 1 ertifying | Physician: To the | e best of my kn | owledge, deat | h occurred a | at the tim | ne, date an | d place, a | and due to the | cause(s) a | and manner as s | itated. |
| | ne Ho na Fui | edicai | (Check only 2 Medical Ex | caminer: On the b | asis of examin ner stated. | ation and/or in | vestigation, | in my op | pinion, dea | th occurre | ed at the time, | date and p | place, and due to | o the cause(s) |
| | To the within 2. To the complete | ž | 29b. Signature and title of certifier | | | | 29c. | . License | e number | -00 | | 29d. Date | signed (Month, | Day, Year) |
|) | | | Scentrali | IC' | ulla | MD | 1 | 2 | 27 | 188 | | 11/ | 236 | > |
| 6 | 7 | | 30. Name and address of person w | no completed cau | se of death (Ite | m 23a) (Type, | Print) |)/- | | À. | 1 | - | 2.0 | 22 |
| 2 | | | 31. Date filed (Month, Day, Year) | 1/1/16 | Registrar's Sign | 147 [Ca | ef r | W | 1 | Ne C | NOIR | 141 |) 211 | |
| | Sta Registr | | MOUS A | 005 | g.o.i.ai o oigi | M. Sono | 1838 | | | | | | | |
| | | ¥ '9 | WELL OF A | UUU ISSE | 13 15 A | 137 | CALL | | | | | | | |